Alcoholism, Native and non-Native treatment technologies and the discourse of difference.

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Alcoholism, Native and Non-Native Treatment Technologies
And The Discourse Of Difference

by

Kelly Henley

A Thesis
Submitted to the Faculty of Graduate Studies and Research
through the Department of Sociology and Anthropology
in Partial Fulfillment of the Requirements for
a Masters Degree at the
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Abstract

This thesis explores the establishment of government-sponsored alcohol treatment facilities for Native people in Canada. An examination of treatment approaches suggests that Native recovery programs are a reflection of other existing treatment technologies. The development of government-sponsored programs represents negotiated territory between “self-determination” and the government’s effort to re-define citizenship.

The following sources of information were included in this project: face-to-face interviews with staff members from different treatment facilities, a review of websites outlining the treatment programs in Native facilities, an analysis of documents on Alcoholics Anonymous and a review of literature that outlines Aboriginality and “governable spaces.”

Seven interviews were conducted between the November 2000 and July 2001. The results suggest that the government-sponsored recovery facilities are not particularly different from most non-Native treatment centres.

The conclusion is reached that applying the A.A. model, despite its emphasis on sameness, allows room for the incorporation of difference into Native recovery programs. Native facilities recognition of distinctiveness permits treatment to be applied in a less inclusive way.
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CHAPTER I

Introduction

Historically, the Canadian government managed Native populations through the relocation of Aboriginal peoples to reserves and residential schools. These locations were spaces where Native peoples\(^1\) could be observed, partitioned and subject to disciplines until they were "civilized" enough to be reintegrated to society (Cohen, 1985, p. 208).

Currently, the Federal government, in part through the development of multicultural policy, has recognized Native Canadians as distinct peoples and has acknowledged this distinctiveness through the institution of a variety of initiatives. One such initiative is the development of alcohol and drug abuse treatment centres designed specifically for Native peoples. This initiative was deemed necessary because First Nations people in this country have been classified as a high-risk population with respect to alcohol abuse, which is often framed as a primary social problem among many Aboriginal communities. Although every community is distinct and generalizations are difficult to make, it has been held that some communities experience rates of alcoholism and abuse that are largely above those found among non-Native peoples (Whitehead & Hayes, 1998). The higher rates of abuse among Native peoples suggests that there are differences from the 'general population.'

A variety of theories have been developed that attempt to explain Indigenous people's substance abuse patterns. According to Kim Scott (1992, p. 4), a consultant for

\(^{1}\) For the purpose of this paper, the terms Native, Aboriginal and Indigenous will be used interchangeably.
the National Native Alcohol and Drug Abuse Program (NNADAP), these theories fall into four broad categories:

1. Historical theories claim indigenous groups were not socially prepared for the potency of alcohol. Without codes or patterns of moderate consumption, use was modelled primarily upon the aberrant, uncontrolled consumption of early frontiersmen.

2. Biological/genetic/physiological theories claim Indigenous people are biochemically prone to crave and lose control over alcohol, and to metabolize it at significantly slower rates.

3. Psycho-social/economic theories purport substance abuse is a coping strategy for forced relocation, broken families, stress, unemployment, poverty, inadequate education, poor health and low self-esteem.

4. Cultural theories allege transitional or bicultural stress and cultural loss precipitate abuse to the more exotic cultural predisposition to seek “visions” in altered states of consciousness.

These four theories, while different, suggest that the circumstances surrounding alcohol abuse treatment among Aboriginal peoples may be unique. This emphasis on uniqueness is reflected in the design of treatment centres specifically for Native peoples and can be illustrated by referring to Poundmaker’s Lodge.

Poundmaker’s Lodge is a well-known alcohol and drug treatment centre for Native people located in Alberta. According to a documentary on Poundmaker’s Lodge, produced by the National Film Board of Canada (1994), many Native peoples feel that alcohol was introduced to Aboriginal communities by early European explorers as a way to “deindianize” the people. According to the documentary, Native peoples hold the
belief that in order to be free from alcohol and drugs, Aboriginal substance abusers must look at what has happened in the past, and begin to embrace the traditions that will heal the wounds inflicted by a long history of alcoholism in Native communities.

The Poundmaker’s Lodge documentary also states that many of the Native people who come to the facility feel that Aboriginal peoples experience with alcohol has been unique from the outset. Some of these people include community leaders who have recognized the devastating effects of alcohol and drug abuse along with the need for programming to reflect and support Native culture and spiritual values (Wiebe, 1994, p. 1). The literature has suggested that it is this recognition that has led to the instituting of “healing lodges,” where the goal is to provide treatment that is specific to the needs of Native people (Maracle, 1993; Wiebe, 1994; Whitehead and Hayes, 1998). Poundmaker’s Lodge is one of the few Native treatment facilities in Canada that has made its history, mission, philosophy and guiding principles available to the general public.

Poundmaker’s Lodge is a Native-founded, Native-managed, non-profit corporation, which makes it unique from many of the government-funded programs that will be discussed in this paper. Alcohol and drug abuse treatment facilities for Native peoples is also part of the Canadian government’s mission to improve and maintain the health of individuals in Native communities. Approximately sixty of these treatment facilities exist across Canada and are sponsored and supported by the National Native Alcohol and Drug Abuse Program (NNADAP). The program was established in 1987 as

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2 In this context, the term healing lodge refers to a drug and/or alcohol treatment facility for Native people.
a Federal initiative governed by the First Nations and Inuit Health Branch. As the website for the NNADAP states this arm of government was established, in part, to:

foster a renewed relationship with First Nations and Inuit communities that are based on the transfer of direct health services, and a refocused federal role that seeks to improve the health status of First Nations and Inuit people.

The NNADAP policy states that the program “provides prevention and treatment services to First Nations persons living on and off reserves. These are residential facilities operating on a psychotherapeutic model, incorporating intensive, culturally sensitive programming lasting 4 to 6 weeks” (http://www.ccsa.ca/mckenzie.htm). The intent of the program is that effective community programs will, in time, decrease the need for inpatient treatment services (http://www.ccsa.ca/mckenzie.htm). NNADAP treatment facilities appear to operate primarily on a medical model, which draws on a disease model of causation and emphasizes the treatment protocol of the Alcoholics Anonymous approach (http://www.ccsa.ca/mckenzie.htm).

The development of Native treatment programs allows Indigenous groups to address the problem of alcoholics within their own communities, granting Native groups the authority to govern themselves using approaches that they have selected. This approach coincides with the Federal government’s policies on multiculturalism. Immigration over the last several decades has altered the Canadian urban landscape and the make up of the Canadian population. Representative of the new Canadian reality is the recognition of distinct cultures and the provision for support services that are required by members of different cultural groups (Madison et al., 2000). Despite the government’s multiculturalism policies and the recognition of the cultural groups ability
to manage themselves, the state maintains some authority over people in government-funded treatment programs by virtue of the monetary support that it provides.

An examination of government-sponsored programs suggests that Native recovery facilities are not particularly different from most non-Native treatment centres. Of particular concern is the principle component of the “treatment technology”\(^3\) that has been adopted. The approach to recovery is an A. A. based model in which the treatment needs are considered to be the same for all alcoholics regardless of any social or cultural differences. That is, the underlying recovery model is based on a discourse of “inclusiveness” whereby the same approach to treatment is deemed to be effective for everyone. On the other hand, non-government sponsored Native facilities categorically acknowledge the importance of cultural difference.

The recognition that some treatment approaches acknowledge difference, while others do not, is the premise that led to the formation of the questions that directed the research for this thesis. How is the apparent contradiction between treatment programs based on A.A. principles and the necessity of having approaches based on the notion of cultural difference managed? How are A.A. principles managed to permit cultural distinctiveness in the development of Native treatment centres? I argue that many Native recovery programs use treatment technologies, that when examined, resemble various other recovery models that were not intended to be imparted as culturally specific modes of care. In addition to the issues outlined above, interesting questions are raised that are

\(^{3}\)The term “treatment technologies” is a variation of the term “technologies of government” as seen in Foucault and Rose, among others. Technologies of government are the strategies, techniques and procedures through which different authorities seek to enact programs that promise to regulate decisions and actions of individuals, groups and organizations in relation to authoritative criteria (Rose, 1999, p.42).
tied to the cultural components incorporated into the treatment programs, and the policies the government imposes, that create spaces in which Aboriginal communities may help shape the recovery process. More specifically, I suggest, is that these spaces represent areas where Native treatment programs can be supported by traditions that are of value to the facilities’ members.

A related question that will be considered addresses the observation that Indigenous peoples in Canada have been increasingly vocal regarding their interest in self-determination. The development of NNADAP sponsored programs is relevant to this issue because it represents negotiated terrain between “self-determination” and the government’s effort to re-define citizenship. The government’s effort to recognize difference is a historical shift that is largely tied to Canada’s multicultural policy. This raises the question of whether or not the programs under consideration in this project sustain this shift toward self-determination. It is not possible to pursue this question in detail, however it will be explored in a general way to suggest that the new relationship that is being fostered, between the Federal government and Indigenous groups, might be seen as a form of governance. This is not to say that Native recovery programs are not valuable in overcoming drug and alcohol addiction.

To support the notion that Native recovery programs are a reflection of other treatment technologies, it is necessary to provide an overview of Native peoples experiences and perceptions of alcohol abuse, review the components of selected Native programs and a non-Native program, highlight structural and philosophical parallels of each and perhaps identify any apparent differences that exist. Special attention will be given to understanding how the fundamentals of Alcoholics Anonymous appear to be
incorporated into Brentwood and Native recovery programs. These factors will be outlined generally here, and discussed in explicit detail, in the chapters that follow.

The adoption of similar treatment technologies by Native and non-Native recovery programs is evaluated on a general level through interview data, observation and website information. I have drawn comparisons on specific tenets between a treatment program that uses many of the philosophies of Alcoholics Anonymous as its foundation, and recovery programs that are designed for Native peoples. I have chosen the Brentwood Recovery Home in Southern Ontario as the “non-Native” A.A. based site. Brentwood was a chosen for this comparison, as it is a facility that has a long history in the community, although it has some unique qualities that will be outlined in subsequent chapters. Interviews were conducted at Brentwood between November 2000 and July 2001. The data collected from these interviews will be used to draw out parallels between Brentwood and the Native recovery programs reviewed for this project.

The literature available on Native treatment centres is quite sparse, and unfortunately, I was unable to secure access to a Native treatment facility. Originally, I had planned to contact Pedahbun Lodge in Toronto. However in November 2000 I was informed that this facility had closed its doors. As a result, in January 2001 I contacted another treatment centre, located outside of Hamilton. A letter was sent to the facilities director, and several attempts were made to contact the staff by phone. However, after months of unsuccessfully trying to set up a meeting with the site director and program coordinator I decided that I would have to seek out alternative sources of information. Consequently, the information used in this investigation consists primarily of data obtained from literature, and data collected from 53 web sites. Since I am comparing
information collected from different sources I must acknowledge potential consequences to drawing conclusions based on this data. These issues will be discussed in the methodology section of this paper.

Existing research suggests that separate programming is required for Native peoples due to their unique experiences with alcohol and the particular ways it has influenced their lives (Maracle, 1993; Whitehead & Hayes, 1998). However, contemporary literature does not appear to address the issue of the existence of inclusive treatment approaches within treatment facilities that acknowledge cultural differences. This research intends to address this gap and suggests that while government-sponsored Native treatment programs are similar to existing treatment technologies, such technologies may be managed at the local level to permit “culturally specific” modes of treatment.
CHAPTER II

Review of Literature

Introduction

Aboriginal people, often represented as a single distinct population, have been subject to a long history of control and moral regulation. The policy of ‘civilization’/assimilation employed by the Federal government up to the 1970s supported the cultural transformation (politically and socially) of culturally distinct peoples. Culturally distinct peoples were stigmatized and whole populations of “morally tainted” people were denied the right to organize their own lives. This situation changed in that opposition of Aboriginal people, expressed in a desire for political/cultural autonomy, has led the Federal government to recognize cultural distinctiveness and acknowledge the desire for self-government. To govern, it is necessary to render visible the space over which government is to be exercised (Rose, 1999, p. 36). It is in this context that Federal programs for alcoholics assume significance. While the government transfers the control of treatment programs to Indigenous peoples, governable spaces are created that may allow room for new kinds of governance. This chapter includes a discussion of two key ideas, ‘governable spaces’ and Aboriginality.

Governable Spaces

Prior to European settlers reaching this continent, Indigenous groups decided their own citizenship, and engaged in a wide variety of governmental systems that regulated their members with a degree of formality (Erasmus & Sanders, 1992, p.3). Today, Indigenous populations in Canada and elsewhere are struggling to retain traditional lands,
cope with government administration of their affairs, and to survive as culturally distinct peoples within nation states (Dyck, 1985, p. 1).

Historically, a variety of mechanisms have been used to shape, control and view Canada’s aboriginal population. In the mid 1800s, education was being used to attain the state’s goal of cultural assimilation. The crown used its agents to design a program of assimilation that was devised to transform Native peoples from nomadic groups to “civilized and settled” Christians (Mawhiney, 1994, p. 23). It was at this time that indigenous groups were being placed in specified territories called reserves. The government believed that if the “Indians” were to be “civilized” they would have to abandon their traditional tribal system of government. Legislation was passed supporting the government’s belief. This was in fact the Indian Act of 1880 with provisions added to destroy the last remains of the traditional political systems held by Indigenous communities (Daugherty & Madill, 1980, p. 14).

The 1951 revisions to the Act were positioned in a manner that was to suggest major changes in the ways in which indigenous people were treated in this country. however, little change materialized. Modifications to the Act granted Provinces authority over Native communities, adding a new dimension to the power relationship that already existed between federal authorities and Indigenous groups. The Indian Act of 1951 failed to allow “Indian” bands to set up their own forms of local government, and to grant band councils decision-making powers. The Act was amended more than twenty times, including revisions in the 1920s and 1950s, illustrating the dissatisfaction and resistance toward this legislation (Mawhiney, 1994, p. 35).
Since the 1960s, Native Canadians have become more vocal regarding the need for particular legislation that would improve the relationships between Native communities and the state. This relationship is often discussed in terms of self-government. However, current literature suggests that some proposals for Aboriginal self-government, made by Canadian political and public officials, are rooted in the desire to maintain control of Indigenous land, and community populations (Adams, 1995; Durst, 1995). The ‘cultural space’ that is created by the transfer of authority and management of alcohol and drug treatment programs to Indigenous groups appears to support Rose’s (1999) claim that therapeutic technologies bring the regulation of subjectivities into line with the new rationalities for the government of individuals in terms of their freedom, autonomy and choice (p. 93).

I suggest that these governable spaces, established with cultural distinction in mind, though limited, enable Native Canadians to address and counteract the inclusivity of the drug and alcohol treatment programs that have been developed on their behalf. As will be discussed later in this paper, the A.A. approach to treatment, although acknowledging some difference between individuals, fails to recognize the potential relevance of ethnic/cultural distinction in the treatment process. While the previous statement may appear to homogenize the discursive space in which Aboriginal treatment needs are played out, Rose (1999) suggests that governable spaces are always shaped and intersected by other discourses. In this case, it is the discourse of exclusivity or difference that creates a ‘cultural space’ that affords Native facilities the opportunity to pursue treatment options that recognize distinction.
Several issues are explored when addressing the question of whether or not government-sponsored Native treatment programs create a space for distinctiveness in the modes of care that are offered. The concept of aboriginal autonomy and its affect on identity are discussed in light of the formation of alcohol treatment programs designed specifically for Native peoples. Native treatment centres are compared, at a principle level, to the Alcoholics Anonymous approach and contrasted with the principles and practices of Brentwood to draw out parallels in recovery methodologies. Literature that outlines autonomy and identity will be reviewed to provide support for further analysis and discussion of the “renewed relationship” between the Federal government and Indigenous groups with respect to the strategies developed to improve the status of health care among Native communities.

**Aboriginality**

The identity associated with Native peoples is often termed Aboriginality, which is part of a discourse surrounding the distinctiveness of Aboriginal people. Once a particular ‘Aboriginal Identity’ is formulated, the very formulation acts to produce a reality within which individuals may find identity and which calls forth certain behaviour. At the same time the world is thus objectivated as a ‘reality’ for actors themselves, it is also presented as a coherent whole to others (Jordan, 1988, p. 110). The task of clarifying what is meant by Aboriginality is critical, not only for the acceptance of modern Aboriginal identity by the general public, but also for the provision of services by the government, which often relies on the identification of Aboriginal people as a special
group, therefore, the discourse of Aboriginality nicely compliments Canada’s multicultural policy (Creame, 1988, p. 45).4

Native peoples often invoke Aboriginality in the pursuit of their own objectives while the government and other organizations define it based on their views. Aboriginal discourse locates identity in history to deconstruct European representations by emphasizing traditional culture. In emphasizing ‘otherness’, Aboriginal discourse establishes itself firmly in opposition to the dominant culture (Ariss, 1988, p. 136).

Identity for Native peoples, as with any other group, may shift depending on experiences. These shifts may include the importance of maintaining a distinctive social identity, which is often stated as the desire to ‘regain what has been lost’. This may include an expression of the need to get back to earlier and superior forms of social life (National Film Board of Canada, 1994). The approach taken by A.A. based models, and Brentwood in particular, does not appear to allow for the modification of treatment based on differences between ethnic groups. For this reason, it has been said that the construction of Aboriginal identity, within treatment centres, may be a resistance to A.A.

Discursive discussions on a distinct identity lead us to believe that it is a constructed term, continually perpetuated from European settlement to the present day.

Berkhofer (1978) points to the example of the shifting definitions over time of the imagery surrounding Native/White relations. The imagery was originally of the “good Indian,” who appeared friendly, courteous, and hospitable to the initial invaders of their

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4 We must proceed with caution when discussing the concept of Aboriginal identity. The references used here involve parallels that can be drawn between Native groups in Australia and Canada; Australian authors have produced much of the academic literature on this topic.
land. These images were soon replaced by those of the “bad Indian” whose habits and customs seemed loathsome to Whites (p. 28).

Native Identity is often discussed in a collective, categorical manner that tends to homogenize indigenous peoples into restrictive categories of “other.” When this categorical identity is imposed on Native people, it makes it difficult for them to maintain their own identity, and to recognize the collective label that often dominates them. Similar concerns have been raised by authors such as Berkhofer (1978), who asks, why do “Whites” insist on using general designations that require the lumping together of all Native Americans as a collective entity? (p. 23). Not only does the general term Indian continue to be used, but also it is used to speak of one band as exemplary of all Native people (Berkhofer, p. 6). This “lumping together” is problematic and can be illustrated by looking at the example of alcoholism, identity and concepts of tradition among Native peoples.

Problems of distinct recognition surface because of socially sustained discourses about who is appropriate to shape the way we look at ourselves. These concerns result in “identity politics” (p. 20). Calhoun refers to identity politics as the struggles that involve power relations, and take on a political edge because they involve “refusing, diminishing, or displacing identities others wish to recognize in individuals” (Calhoun, p. 21). According to Calhoun, this displacement is well known within ‘racial’ identities and is apparent in the chronic replacement of collective labels that have come to impose identities that contrast with the identity claims of those labelled (p. 21). Morris (1988) asserts that the politics of identity is an expression of resistance to attempts to make
Native peoples experience themselves in the terms defined by the dominant society (p. 77).

**Conclusion**

Native people are political actors, their experience of the politics of identity is found in the attempts made by Native peoples and their organizations to draw and shape the discourse on Aboriginality as they pursue their own objectives. In this context the objectives pursued include occupying ‘governable spaces’ available in government-sponsored treatment programs in a way that enables Native facilities to embrace the traditions that are of value to the facility and its members. While it is not possible to describe the way ‘cultural space’ is occupied because of the inability to conduct research in a Native facility, it is possible to investigate the context of the space through a discussion of Brentwood.
CHAPTER III

Procedure

Three sources of information make up the focus of this project; they include interviews with staff members from different treatment programs, an analysis of literature on Native treatment approaches and Alcoholics Anonymous programs and a review of web sites that outline the programs offered at Native treatment centres.

Qualitative Research Paradigm

According to Creswell (1994), the qualitative research paradigm is "an inquiry process of understanding a social or human problem, based on building a complex holistic picture, formed with words, reporting detailed views of informants, and conducted in a natural setting" (p. 7). The literature suggests that qualitative methodology can be set apart from quantitative research by a number of assumptions that make up the design. For example, Merriam (1988 as cited in Creswell, 1994) has advanced six assumptions that are as follows: (1) Qualitative researchers are concerned primarily with process, rather than outcomes or products. (2) The qualitative researcher is the primary instrument for data collection and analysis. (3) Data are mediated through this human instrument, rather than through inventories, questionnaires, or machines. (4) Qualitative research involves fieldwork. (5) The researcher physically goes to the people, setting, site, or institution to observe or record behaviour in its natural setting. (6) Qualitative research is descriptive in that the researcher is interested in process, meaning and understanding gained through words or pictures (p. 145).
The issues addressed in this study are well suited to a qualitative design since the qualitative paradigm supports exploratory research in which the variables and theory are unknown (Creswell, 1994, p. 9).

**Comparative Case Study Design**

This project uses the comparative case study approach to explore the question of whether or not Native treatment programs are rooted in A.A. principles while allowing room for a distinct cultural mode of care. In doing so, several websites outlining Native facilities will be looked at, as well as a treatment program that makes no stipulation on who they admit. The Alcoholics Anonymous approach to treatment was used as a measure of comparison for this project.

The case study design involves systemically collecting information through interviews, websites and literature about a particular person, social setting, event or group to permit the researcher to understand effectively how it operates or functions (Berg, 1998).

**Selection of Sites/Gaining Access**

Brentwood Recovery Home was chosen as the “non-Native” A.A. based model for this project. This drug and alcohol facility has been a fixture in the community for more than 35 years. I contacted the director of Brentwood, explaining the purpose of the project and asked for permission to speak to staff members.

Due to the difficulty I had securing access to a single Native treatment facility, the decision was made to include information collected from many different websites. There are approximately 60 government-sponsored Native treatment centres across Canada as
as a variety of other programs that are not government funded, and offer a variety of
services including addictions counselling.

**Data Collection/Interviewing**

I employed two data collection methods for this project. I used data collected
from face-to-face interviews, as well as an analysis of documents and web sites. I made
no attempt to randomly select participants who were asked to participate in the interviews
that I conducted.

I conducted 7 interviews between November 2000 and July 2001. With the help
of Brentwood’s director, I recruited staff members to participate in this research.
Participants were selected on a voluntary basis; however, I requested that staff members
be employed at the facilities for at least three months in order to be included in this study.
The reason for this stipulation is so participants who volunteered would have been
involved in the program long enough to talk about the philosophies and organization of
the recovery model.

The face-to-face interviews were tape-recorded after each participant granted
permission. I also used a notebook to write down further questions during the interview
since it was conducted using an active interview format. In this sense, the tape-recorded
interviews closely resemble conversations.

In regard to Native treatment facilities, 53 websites were reviewed to collect
information that could be compared to information gathered from Brentwood Recovery
Home. The sites varied from Health Canada, NNADAP, individual Native facilities and
articles and papers that discuss alcoholism in Native communities.
Data Analysis

My data analysis includes organizing a large quantity of information into a coherent picture (Neuman, 1997). Interview transcriptions, literature and websites were sorted through with categories of information in mind that then formed the basis of codes. According to Creswell (1994), these categories and codes are the foundations for the emerging story to be told by the qualitative researcher (p. 167). As I read my interview notes, and reviewed website data, I began to pick up on key words that highlight points of comparison between treatment programs. Key words and phrases that I looked for include responses that focus on distinctiveness, what was seen as diverse and similar between the various programs, particularly in regards to their philosophy and organization.

When staff members of Brentwood were interviewed I looked for responses that discuss what the aim of the programming is, whether or not they felt the programming is useful to anyone who has substance abuse problems, and whether or not they saw the necessity for separate facilities for Native peoples. From the patterns that arose out of the participants’ varying perspectives, along with how I interpret them, I began to tie or link different pieces of interview data together (Emerson, Fretz & Shaw, 1995, p. 162).

Analysis of Documents

The analysis of documents and websites serves a variety of functions. It allows me to draw out parallels between A.A., Native treatment programs and Brentwood Recovery Home. The discourse embedded in discussions of Aboriginal people and alcohol has been examined through the analysis of documents like those published on the
National Native Alcohol and Drug Abuse Program, and other provincial programs like Alberta’s Alcohol and Drug Abuse Commission. Analysing documents specific to the Alcoholics Anonymous approach was also undertaken to help illustrate how treatment technologies have been transmitted from one program to another.

**Reporting the Findings**

This project is using the comparative case study format to compare Native and non-Native alcohol treatment programs and analyse the similarities in the philosophies and organization of each program. The completed project examines the ways in which treatment programs, based on the principles of A.A., permit a degree of ‘cultural space’ that allows for the incorporation of distinctiveness in the treatment process. This is explored through a presentation of the similarities and differences that exist in treatment programs based on information collected from interviews, literature and web sites. Although the data collected during the course of the Brentwood interviews is more detailed and diverse than the data obtained from the websites that were reviewed, the analysis that is conducted focuses on information that allows comparisons to be made at the same level.

**Ethical Considerations**

Prior to commencing this project, a proposal was reviewed by the Ethics Committee of the Department of Sociology and Anthropology. Seven people were interviewed for this project from two different organizations. Voluntary informed consent was secured from each of the seven interviewees. This included a consent form that outlines the purpose of this research project, and any potential risk and benefit. In
addition, I made each interviewee aware that they could discontinue their participation in the research at anytime. I maintained confidentiality at all times, and I have protected the identity of the participants by using numbers instead of names within the text whenever it is necessary, particularly when a direct quote is being used. I have taken every precaution to ensure that notes I have made during the course of an interview, or through observation, remain within my possession, and have been coded in such a way that identities would not be discernable to an outside source.

**Limitations**

I faced many challenges and obstacles while conducting this research. Obviously first and foremost, as discussed previously, was the inability to secure access to a Native treatment facility. Once I realized that I would be unable to access a Native facility, I was too far into my research at Brentwood to make major changes to the project. This forced me to rely primarily on current literature that discussed addictions treatment for Native peoples.

Unfortunately the literature that is available on addictions treatment facilities for Native peoples is very limited; therefore I had to seek out information from alternative sources. I was able to access many websites that provided a variety of information on alcoholism in Native communities and the treatment offered in Native recovery facilities.

An issue to consider when using web-based information is that the data that is published on the websites may not be what occurs in practice at the facilities. Therefore, any statements or ideas that are derived from this information are limited because they cannot be reviewed against the actual process followed in the centres. The second
consequence of using information from the Web is that the data collected during this project is from two different sources of information, interviews and web sites. This will restrict me to making comparisons on one level, since the information on actual practices that occur in Native facilities was not available to me. Therefore, a direct comparison can be made only on a structural and philosophical level.
CHAPTER IV

Alcoholics Anonymous

Alcohol treatment facilities were examined for this project to explore the degree of 'cultural space' within Native treatment programs. More specifically, this paper addresses the question of whether or not 'cultural spaces' allow room for the application of distinct treatment processes.

There are similarities in the organization and underlying philosophy of the treatment programs and approaches that were explored during the course of this project. Many of these points of comparison can be traced to the fundamentals of the Alcoholics Anonymous (A.A.) movement. To draw parallels between the programs based on A. A. principles, it is necessary to include a discussion of Alcoholics Anonymous in this paper. This section will outline the historical development, organizational structure, and underlying philosophy of Alcoholics Anonymous.

Background and Historical Development

"Alcoholics Anonymous is a fellowship of men and women who share their experience, strength and hope with each other that they may solve their common problem and help others to recover from alcoholism" (http://www.alcoholics-anonymous.org).

A.A. is known as a mutual-help organization with millions of members world wide, but as with many major organizations, the birth of this fellowship lay in the hands of a few committed individuals.

As A.A. folklore goes, its roots can be traced to the meeting of two professionals who were both "alcoholics"—William Wilson (known as Bill W.) and Robert Smith (Dr.
Bill W. was a stock company investigator living in New York, and Dr. Bob worked as a physician in Akron, Ohio (Makela et al., 1996, p. 19).

Bill W. was in Akron Ohio on a business trip where he found himself tempted to have a drink. He immediately began trying to find another alcoholic with whom to share his experience, in the hopes that such “evangelism” would help him to not take a drink. The alcoholic Bill W. sought out was Dr. Bob Smith, a surgeon who shared his common problem with alcohol. Some weeks after their encounter, on June 10, 1935, Dr. Bob reportedly took his last drink. Since then, this chance meeting in Ohio has been regarded as the founding site of Alcoholics Anonymous (Makela et al., 1996, p. 19).

In the latter half of 1935, Bill W. met with Dr. Bob in Akron, and together, they developed the basic ideals and principles of Alcoholics Anonymous. Both founders had experience in the evangelical Protestant movement of spiritual renewal known as the Oxford Group movement. At that time, the Episcopal clergyman, Dr. Samuel Shoemaker, directed the Oxford Groups in America.

The new program that Dr. Bob and Bill W. developed consisted of talking to, helping, and maintaining contact with others who were unable to control their drinking, and taking part in some kind of spiritual activity, which in the early days, consisted of attending local Oxford Group meetings (Makela et al, 1996, p. 19). The two men began to work with alcoholics at Akron’s City Hospital, and achieved success with one patient who quickly reached complete sobriety. These three men made up the core of the first A.A. group, although the name had not yet been coined (http://www.alcoholics-anonymous.org). According to A.A literature, a second group of alcoholics took shape in
New York, and a third appeared in Cleveland in 1939. These were recognized as the three founding A.A. groups (http://www.alcoholics-anonymous.org).

The number of recovering alcoholics who were affiliated with what we now call A.A. grew slowly in Akron and New York, and over the next two years the nameless fellowship began to take on an existence of its own (Makela et al., 1996). In 1937, the New York fellowship separated from the Oxford Group, while the Akron group remained loyal to the movement.

In 1939, the Fellowship published its first book, Alcoholics Anonymous. Bill W. was the author of the text and in it he explained A.A.’s philosophy and methods, which would later evolve into the “Twelve Steps.” The title of the book became the movement’s name. In the months that followed the publication of the “Big Book,” the movement received a great deal of publicity that attracted the attention of problem drinkers across the nation. This national publicity brought a flood of new members, and A.A. became a nationally recognized movement (Makela et al., 1996, p. 21).

**Milestones in the History of A.A. in the United States and Canada**
(Source: Alcoholics Anonymous as a Mutual-Help Movement-1996)

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
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<tbody>
<tr>
<td>1935</td>
<td>June 10. Dr. Bob has his last drink. A.A.’s official starting point.</td>
</tr>
<tr>
<td>1938</td>
<td>May. Alchoholics Foundation formed to raise funds. Works Publishing Inc. formed to publish a book describing A.A.</td>
</tr>
<tr>
<td>1938</td>
<td>December. Twelve Steps written.</td>
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<tr>
<td>1939</td>
<td>April. Alcoholics Anonymous published.</td>
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<tr>
<td>1939</td>
<td>October. Akron A.A.’s separate from Oxford Group. A.A. is now independent of other organizations.</td>
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<tr>
<td>1940</td>
<td>First World Service Office for A.A. in New York.</td>
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<tr>
<td>1941</td>
<td>March. Saturday Evening Post article gives A.A. national publicity. Membership grows from 2000 to 8000 in the last 10 months of 1941.</td>
</tr>
<tr>
<td>1944</td>
<td>Formation of the National Committee for Education on Alcoholism (later called the National Council on Alcoholism).</td>
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<tr>
<td>Year</td>
<td>Event</td>
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<tr>
<td>1944</td>
<td>First publication of the A.A. <em>Grapevine.</em></td>
</tr>
<tr>
<td>1946</td>
<td>Publication of the first version of the Twelve Traditions in A.A. <em>Grapevine.</em></td>
</tr>
<tr>
<td>1946-1949</td>
<td>Memoranda from Bill W. to trustees; trustees opposed to creating a conference or even an advisory council.</td>
</tr>
<tr>
<td>1950</td>
<td>First International Convention in Cleveland. Adoption of the Twelve Traditions and the Third Legacy (Service) proposal establishing a five-year experimental General Service Conference (United States and Canada) to meet annually.</td>
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<tr>
<td>1950</td>
<td>Conference plan approved by trustees.</td>
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<tr>
<td>1950</td>
<td>Death of Dr. Bob.</td>
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<tr>
<td>1951</td>
<td>First General Service Conference in New York begins a five-year experimental period.</td>
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<tr>
<td>1951</td>
<td>Publication of the <em>Third Legacy Manual</em>, later called the A.A. <em>Service Manual</em>, describing the principles of conference organization for the United States and Canada.</td>
</tr>
<tr>
<td>1953</td>
<td>Publication of <em>Twelve Steps and Twelve Traditions.</em></td>
</tr>
<tr>
<td>1954</td>
<td>Alcoholics Foundation renamed General Service Board of Alcoholics Anonymous. The majority of the trustees remain non-alcoholic.</td>
</tr>
<tr>
<td>1955</td>
<td>Fifth General Service Conference takes over the leadership of A.A.: adoption of the General Conference Charter (North America) establishing a representative service structure linking the membership to the General Service Board.</td>
</tr>
<tr>
<td>1959</td>
<td>A.A. Publishing Inc., becomes A.A. World Services, Inc.</td>
</tr>
<tr>
<td>1966</td>
<td>Change in the General Service Board (United States and Canada) to provide that two-thirds of the board be composed of alcoholic members.</td>
</tr>
<tr>
<td>1971</td>
<td>Death of Bill W.</td>
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**Organizational Structure of A.A. in the U.S. and Canada**

Alcoholics Anonymous describes itself as a loosely ordered organization, particularly at the local level. There are no formal regulations to enforce, no dues, or governing officers. According to the official A.A. website, http://www.alcoholics-anonymous.org, there are two operating bodies:

1. A.A. worldwide services, directed by A.A. World Services, Inc., are based in the General Service Office in New York City. This office is staffed by 84 workers who are
responsible for keeping in touch with local groups, with A.A. groups in treatment and
correctional facilities, with international members and groups, and with thousands of
"outsiders" who rely on A.A. each year for information. A. A. conference-approved
literature is prepared, published, and distributed through this office.

2. The A. A. Grapevine Inc., publishes the A.A. Grapevine, the Fellowship’s
monthly international journal. Currently, the magazine has a circulation of
approximately 125,000 in the U.S., Canada, and other countries. The journal also
produces a selection of special items, predominantly cassette tapes and anthologies of
magazine articles, which are offshoots of the magazine.

The operating organizations answer to a board of trustees (General Service Board
of A.A.). The board is made up of seven nonalcoholic supporters of the fellowship, and
fourteen A.A. members (http://www.alcholics-anonymous.org).

Once a year a General Service Conference is held. Attendees of this meeting
include 92 delegates from A.A. areas in the United States and Canada, trustees,
A.A.W.S., Grapevine directors, and staff from the General Service Office and the
Grapevine. This meeting serves as a link between the groups throughout the U.S. and
Canada and the trustees who serve as keepers of A.A. tradition and interpreters of
policies affecting the Fellowship as a whole. At the local level, the group may have a
small steering committee and a limited number of rotating officers, whose role would
include organizing meeting programs, offering refreshments, participating in regional
A.A. activities, and maintaining contact with the General Service Office. All A.A.
service positions operate on a rotating basis. Within the local group, positions are rotated
every six months to a year. Those who are assigned to the General Service Conference
traditionally serve for up to two years and alcoholic trustees of the General Service Board are limited to a four-year term (http://www.alcohics-anonymous.org).

The Twelve Traditions of A.A. are the primary source of the group’s organizational principles; they were formulated and first published in 1946 to outline the means by which A.A. maintains its unity and relates itself to the world (Alcoholics Anonymous World Services, Inc., 1952, p. 15). During the early years when the fellowship began to grow, questions arose regarding membership, money, personal relations, public relations and management of groups. The Twelve Traditions were written to address these concerns and appear to remain unchanged since formulated in 1946. The Twelve Traditions are what give A.A. its present form, substance and unity (Alcoholics Anonymous World Services, Inc., 1952, p. 18). Several of the traditions have been adopted into other alcohol treatment programs including Brentwood Recovery Home. It is therefore necessary to identify each of the traditions, and provide commentary for some, so that parallels may be drawn in subsequent chapters.

The Twelve Traditions are as follows:

(1) Our common welfare should come first; personal recovery depends upon A.A. unity.

(2) For our group purpose, there is but one ultimate authority—a loving God as he may express Himself in our group conscience. Our leaders are but trusted servants; they do not govern.

(3) The only requirement for A.A. membership is a desire to stop drinking.

This tradition applies to the inclusive nature of the Brentwood program. However, the tradition does not apply to Native treatment programs because they require individuals entering treatment to be of Native descent. The desire to stop drinking is not enough to enter the program.
(4) Each group should be autonomous except in matters affecting other groups of A.A as a whole.

(5) Each group has but one primary purpose—to carry its message to the alcoholic who still suffers.

(6) An A.A group ought never endorse, finance or lend the A.A name to any related facility or outside enterprise, lest problems of money, property and prestige divert us from our primary purpose.

(7) Every A.A group ought to be fully self-supporting, declining outside contributions

Brentwood does not aim to be self-supporting as part of the programs funding comes from the government. Many of the Native programs discussed in this project are also government funded. However individuals involved in some centres feel that receiving government funds makes it more difficult to achieve “culturally specific” treatment (Interview 7, 2001).

(8) Alcoholics Anonymous should remain forever nonprofessional, but service centers may employ special workers.

(9) A.A., as such, ought never be organized; but we may create service boards or committees directly responsible to those they serve.

Brentwood and Native treatment facilities employ Executive Directors, Program Coordinators and Social Workers rather than just service boards and committees.

(10) Alcoholics Anonymous has no opinion on outside issues; hence the A.A. name ought never be drawn into public controversy.

(11) Our public relations policy is based on attraction rather than promotion; we need always maintain personal anonymity at the level of press, radio and films.

(12) Anonymity is the spiritual foundation of all our traditions, ever reminding us to place principles before personalities (http://www.alcoholics-anonymous.org).

As the Twelve Traditions suggest, the organization of Alcoholics Anonymous makes no reference to individual differences and embodies a discourse of inclusiveness that does not contemplate distinct groups, including Native Canadians. This discourse of inclusiveness will be furthered explored in this chapter and the chapters that follow.
By the 1960s, A.A. had created a representative structure, with yearly conferences of delegates choosing the General Service Board. Following the model from the United States and Canada, A.A. in other countries adopted the custom of calling its representative structure "the service structure." This term was chosen based on the democratic ideals of the movement: according to Tradition Two, "Our leaders are but trusted servants; they do not govern" (Makela et al, 1996, p. 23).

There are certain tasks that have to be carried out in every A.A. group. In the local group, the following tasks need to be undertaken: look for, and secure, a suitable meeting place; set up a meeting schedule and program; provide refreshments; and keep in touch with the national and international development of A.A. When a local group is just starting out, self-appointed workers may assume responsibility for these tasks. As soon as possible, however, these responsibilities are, by election, rotated to other members in the group for a limited period of time. A typical local group may have a chairperson, a secretary, a program committee, a food committee, a treasurer, and a general service representative who attends regional or area meetings (http://www.alcoholics-anonymous.org).

The Program

According to the ‘official A.A. website,’ the local group meeting is the centre and the heart of the A.A. Fellowship. There are two types of A.A. meetings, the ‘open’ meeting and the ‘closed’ meeting. An open meeting of A.A. is a group meeting that any member of the community, alcoholic or non-alcoholic, may attend. The only requirement is that the names of A.A. members must not be disclosed outside the meeting.
Most often, the average open A.A. meeting will have a “leader” and other speakers. According to the A.A. website, the leader opens and closes the meeting and is responsible for introducing each speaker. Typically, the speakers at an open meeting are A.A. members. The members usually share their story, or drinking experience, that led them to join A.A, along with what sobriety has meant to them personally. Open meetings draw to a close with a social time during which refreshments are served (http://www.alcholics-anonymous.org).

Attendance at closed meetings is restricted to members of the local A.A. group, or visiting members from other groups. These meetings give members an opportunity to discuss specific phases of their alcoholism that can be best understood by other alcoholics. Closed meetings are conducted as informally as possible, and all members are encouraged to share in the discussions. Newcomers are particularly encouraged to attend closed meetings, since it gives them a chance to ask sensitive questions, and benefit from a “senior” members’ experience in the program (http://www.alcholics-anonymous.org).

The frequency of attendance at A.A. meetings is strictly an issue of individual preference and need. Most members try to attend a meeting at least once a week, while others attend meetings almost every night (http://www.alcholics-anonymous.org).

The “Twelve Steps” are the core of the A.A. program; they were written by Bill W. in 1938. According to the A.A. website, they are not abstract theories, but are based on the trial and error activities of early A.A. members. The steps describe the attitudes and activities that the early members believed were critical to their quest for sobriety, and as with the Twelve Traditions, the steps appear to remain unaltered from when first
published (http://www.alcoholics-anonymous.org). A.A. supporters state that members who make an honest effort to follow the Twelve Steps, and apply them to their daily life, get more out of A.A. than people who view the steps casually. The “official” position of A.A. is that the Steps are absolutely necessary if they are to maintain their sobriety (http://www.alcoholics-anonymous.org). As stated with the Twelve Traditions, it is necessary to outline the Twelve Steps, and include remarks that will be useful in the upcoming analysis of A.A., Brentwood and Native treatment programs.

The Twelve Steps are as follows: (Jensen, 2000, p. 52, 54, 56).

1. Admitting you are powerless over alcohol, that your life has become unmanageable

   At A.A., Brentwood and Native facilities this powerlessness is often discussed in terms of a lack of balance in one’s life. The first step to restoring this balance occurs through the recognition that help is needed, and sharing personal stories that will help identify where the imbalance lies.

2. Come to believe that a Power greater than yourself could restore you to sanity

   In A.A. and Brentwood the Higher Power is often referred to as God. The information on Native treatment facilities often refers to the Higher Power as the Creator or the Great Spirit.

3. Make a decision to turn your will and your life over to the care of God as you understand him

4. Make a searching and fearless moral inventory of yourself

   Occurs through the sharing of stories in A.A., Brentwood and Native treatment programs.

5. Admit to God, to yourself, and to another human being the exact nature of your wrongs

6. Be entirely ready to have God remove all of your defects of character

7. Humbly ask Him to remove your shortcomings
(8) Make a list of all persons you have harmed, and become willing to make amends to them all.

(9) Make direct amends to such people wherever possible, except when to do so would injure them or others.

(10) Continue to take personal inventory and when you are wrong promptly admit it.

(11) Seek through prayer and meditation to improve your conscious contact with God, as you understand Him, praying only for knowledge of His will for us and the power to carry that out.

(12) Having had a spiritual awakening as the result of these steps, try to carry this message to alcoholics, and to practice these principles in all your affairs.

The notion of an inclusive discourse was raised in the previous section that outlined A.A.’s Twelve Traditions. A similar discussion can be had regarding the Twelve Steps. While the steps allow for the recognition of difference among individuals and groups of people, the wording of the steps and the method by which they are carried out renders any distinction irrelevant. Each individual who enters A.A. must adhere to and apply the Twelve Steps uniformly to their lives to be successful in A.A. This discourse of sameness reflects a common psychology that does not acknowledge different ways of looking at the world that may affect an individual’s recovery. Varying perspectives are dismissed, as difference is held secondary to inclusiveness.

This chapter has outlined the structural and philosophical components that make up Alcoholics Anonymous, including the historical development, organizational structure, and underlying philosophy of the program. More specifically, the Twelve Traditions were outlined as the core organizational principles of A.A. In addition, the Twelve Steps were reviewed as they are said to describe the attitudes and activities that are necessary for achieving sobriety. Comments were made regarding the transfer of
specific Steps and Traditions to Brentwood Recovery Home and Native treatment facilities. The language of A.A.'s Twelve Steps and Traditions promotes a discourse of inclusiveness that suggests that difference is irrelevant. In other words, while such differences between individuals may be noted, it is presumed that they have no part to play in the delivery of the treatment process. This discourse of sameness is one that is also apparent in the Brentwood program and will be reviewed further in the following chapter.
CHAPTER V

Brentwood Recovery Home

Brentwood Recovery Home was chosen as the non-Native treatment model for this project as its rationale is rooted in several of Alcoholics Anonymous' twelve steps and traditions. This chapter will outline the historical development, underlying philosophy and organization of the Brentwood model. These topics will lay the groundwork for further analysis based on the evaluation of similarities in the organization and philosophies of A.A and Native recovery programs.

Background and Historical Development

Brentwood is a drug and alcohol rehabilitation centre that has been serving the community in the Windsor and surrounding area since 1964. It began as a 10-bed facility serving meals to transients and providing beds for alcoholics. Today, it is the largest centre of its kind in Canada, with two hundred beds, and services that include inpatient, outpatient, day-care, and school education programs (Gallant, 1992, p. 1).

There are three key people who were involved in the development of Brentwood. Fr. Paul Charbonneau, who acted as both administrator and director, and Jim and Kay Ryan, who attended to the counselling, funding, and all of the required details that had to be met to ensure that the program ran efficiently (Gallant, 1992, p.61).

According to Gallant (1992), Fr. Paul's interest in working with alcoholics began in 1952 when he was involved in the Air Force. Many of the servicemen's wives sought out Fr. Paul in desperation, seeking advice about their alcoholic husbands. As a result, Fr. Paul held the first A.A. meeting on an Air Force Base in Canada (p. 133).
After his involvement with the Air Force, Fr. Paul regularly met with seven alcoholic men in his rectory who were also members of A.A. Fr. Paul felt that it was necessary for the group to reach out to other people, and this need to reach out was the force behind the creation of Charity House. In 1965, the economy was in a recession, and Fr. Paul was acutely aware of the number of men in the community who were unemployed, sleeping on the street, and predominantly alcoholic (Gallant, 1992).

Charity House began in a restaurant on Wyandotte Street East, and only had a few supporters. Fr. Paul attempted to purchase a hall on Chilver Road, but residents and business owners signed a petition to prevent him because they were afraid that it would affect the value of their properties. Fr. Paul was able to convince the residents that their fears were misdirected and Charity House opened shortly after (Gallant, 1992, p. 135). At that time it was more like a hostel than a treatment centre.

Jim and Kay Ryan helped Fr. Paul run Charity House for ten years. There were many volunteers who pitched in during that time. Everyone in the organization was either a volunteer, or worked on a part-time basis (Gallant, 1992, p. 139, 140). The typical clientele of Charity House were single, unemployed, homeless, alcoholic men. Individual counseling and group discussions were available to alcoholics at Charity House. The philosophy was never to turn anyone away and the doors were open to everyone without exception (Gallant, p. 143).

Eventually, the needs of the people who frequented Charity House were provided by social services, and it was decided that Charity House was no longer needed. After ten years of service with Charity House, the government went to Fr. Paul and asked him to start a recovery home, though they felt that the facilities at Charity House were not
appropriate. Fr. Paul, along with Jim and Kay Ryan found a house on Sandwich Street, and the government approved. It was determined that the facility would hold a maximum of twenty alcoholics. The Bishop of London appointed Fr. Paul to Brentwood full-time in June of 1977 (Gallant, 1992).

Ultimately, an addition had to be put onto ‘Brentwood on Sandwich’ because people were sleeping in the halls, on sofas, or anywhere else they could find room (Gallant, 1992, p. 150). As the program grew, the facility could no longer accommodate the number of people that were in need of help. It was then discovered that Elmwood (previously a casino) was for sale. This building was eventually purchased, and turned into Brentwood’s current facility (Gallant, p. 150).

**Funding**

The Ministry of Health provides approximately 50 percent of the funds required to run the program at Brentwood. The remaining 50 percent of the funds required to operate Brentwood come from running lotteries, bingos and general fund-raising, through corporate gifts and individual donations, most of which come from Brentwood alumni (Interview 3, 2001). The Brentwood alumni stage special fund-raising events like dances, socials and picnics, to raise money throughout the year (www.brentwood.on.ca).

**The Program**

Brentwood’s program offers a variety of services and facilities including individual and group therapy, and a fully staffed medical clinic that is available to deal with most health problems. A physician is accessible two days a week, and nursing staff
are available in the clinic Monday through Friday, from 8:00am to 4:30pm
(www.brentwood.on.ca).

There are certain basic prerequisites that are necessary in order for a person to
benefit from the Brentwood experience. In order for the Brentwood experience to be
effective, it requires “(1) residents who have a strong incentive for recovery, (2) the sense
of a shared community through the experience of strong relationships, (3) people on
program who can model for the residents a new life-style and (4) a program which
provides a spiritual intensity and relevance” (Gallant, 1992, p. 35). Referrals to the
program are accepted from hospitals, physicians, community agencies, companies,
families and self-referrals. A simple phone call will begin the process (Interview 1.
2000). Assessment prior to admission is required in order to determine an individual’s
suitability for the program. The program is very intense and has members involved in
emotionally draining activities for twelve hours every day. The social worker on staff
must make sure the individuals are physically well, so they can handle Brentwood’s
rigorous program. The assessment of a potential member ends by pairing them up with a
senior person ‘on program,’ who will answer any questions they have, and give them a
tour of the facility.

Once a person is admitted to Brentwood, they are assigned to a home group.
They meet, and continue in the same group from the first day they begin the program, to
the day that they leave (Interview 6, 2001). The size of the home group depends on how
many people are ‘on program’ at a given time. On average the home groups consist of
approximately eight people. Each group is assigned a staff leader who is a member of the
Brentwood alumni. The idea behind staying with the same home group from day one to
graduation is built on developing the ability to trust, and the degree of sharing that unfolds is based on this trust (Gallant, 1992). Each group meeting that a member attends, whether it is an inventory meeting, a commitment meeting, or a meeting based on one of Fr. Paul’s talks, involves the sharing of stories and experiences. Members in the same home group begin to familiarize themselves with the stories of their fellow members and begin to take comfort in this familiarity. So much of an individual’s time at Brentwood is spent with their home group that they quickly come to trust the members of the group and are more willing to open up, and share their experiences freely.

Most people are admitted for 21 days. At the end of that period, they are interviewed, and given the choice of either continuing in the program for the full ninety days, or receiving a certificate that says they have successfully completed the 21 day program (Interviews 1 & 4, 2000, 2001).

All of Brentwood’s programs and services are also available to women. The women who are ‘on program’ at Brentwood stay in a separate facility. However all of the home groups are co-ed. The women and men are kept separate at all times, with the exception of the small group meetings. The men and women are not permitted to talk to each other, look at each other, or fraternize in any other way. They eat meals on separate sides of the cafeteria, and sit on separate sides of the hall during the larger meetings. When I asked why the men are women were so segregated, it was explained to me that recovery is difficult enough when you are focusing your full attention on addressing your feelings, and opening your heart, and when you introduce the possibility of establishing relationships, it makes the path toward recovery even more difficult (Conversation. 2001).
Clients benefit from the guidance of professionally trained staff with expertise in addictions. Group leaders are integral to this process. Group leaders oversee structured group sessions that are designed to bring out the feelings and emotions that every alcoholic experiences (See Appendix A). The group leaders feel that accessing one’s feelings by sharing stories and experiences are the only ways an alcoholic can begin to recover. This statement supports the notion that Brentwood relies heavily on A.A.’s Twelve Steps and Traditions. In particular, the sharing of stories that reflect feelings and emotions is a combination of Steps four and five that address searching yourself and admitting your wrongs to God and others.

While talking to group leaders, I wondered if this structured set up and routinized program was more appealing to certain groups and limited the participation of others. The group leaders feel that accessing one’s feelings by sharing stories and experiences are the only ways an alcoholic can begin to recover. When group leaders were asked whether people of various backgrounds and beliefs can benefit from this method of treatment, they responded that “recovery needs to be the same for everybody” (Interview 3, 2001), and “people are people with the same needs” (Interview 1, 2000). When asked whether they see the need for distinct facilities for Native people one group leader said, “only for their own comfort level, we all have the same feelings regardless of our background, and it doesn’t matter what stories we tell, as alcoholics, the same feelings are affected” (Interview 2, 2000). Although it appears to me that the regimented program and nature of the group meetings do not take difference into account, the group leaders feel that this is not necessary in the treatment of the alcoholic. Recovering from addiction is not about who you are, where you came from, or what you believe, instead it
is about why you drink, and the feelings you have that are tied to the reasons you drink
(Interviews 1-6, 2000, 2001).

Members

Individuals who are on program at Brentwood are referred to as members. Other
treatment facilities often call recovering alcoholics residents. This difference, that at first
appears minor, speaks volumes about the nature of Brentwood’s program. Although
Brentwood is a large residential facility, the members quickly become very attached to
each other. Many of the women that I spoke to said that they feel that they have made
very strong connections with some of the other women ‘on program.’ The women felt
that the structure and intensity of the program, along with the close proximity that is
maintained, fosters a family atmosphere that often makes it difficult for individuals to
leave once they have graduated from the program.

Members are assigned to small groups so that they can feel a sense of belonging
and grow throughout their recovery process. All members are encouraged, and expected.
to contribute to the group sessions. They must attend all group meetings, pay attention to
the group leader, show respect for all members of the group, and be upfront about their
life and process of recovery (Gallant, 1992, p. 72). The individuals ‘on program’ at
Brentwood are not separate ‘residents’ who are only concerned about their own recovery.
rather, they are members of a fellowship who share very personal experiences that bond
them together in a meaningful way.

According to Gallant (1992), the role of group members is to share their stories
and experiences and to offer each other support and hope. Sharing allows the members to
realize that they all suffer from the same afflictions of character. These afflictions of character may include the inability to be honest and truthful, the need to blame others, the inability to acknowledge and express your feelings, the inability to love and the inability to live life responsibly (Interviews 1-5, 2000, 2001). Alcoholics are accountable to each other. When group members truthfully share their stories and experiences, they are set free to begin recovery (Interview 2, 2000). Each person depends on others for his or her sobriety; this is the key to the Brentwood fellowship (p. 72).

Although the fellowship nature of the program is what draws many people to Brentwood, it may also serve to alienate, and hinder the continued recovery of others. The ongoing cohesiveness that the Brentwood fellowship suggests works well for members/graduates who live in the area surrounding Brentwood. However, for individuals’ who come from out of town to begin their program at Brentwood, the ideal of continuing in the fellowship after graduation is virtually impossible. This group culture can be seen as one of the possible limitations of the Brentwood fellowship, especially for Native people who travel to Brentwood to participate in the program, and return to their community upon graduation. They would not have the ongoing support of the fellowship that is so strongly recommended by all staff members at Brentwood.

**Group Leaders**

The five staff members who were interviewed function as group leaders and were able to offer valuable insight into their designated roles. Gallant (1992) also writes on the role of group leader; both accounts reflect similar duties. The primary role of the group leader is to make him/herself available to the residents. The leader’s duties are varied
and wide reaching, and include: ensuring that each resident is doing their program; providing leadership; facilitating group and one-on-one meetings; sharing their experiences; ensuring group discussion stays on track; commenting on inventories; referring problems to counselling staff; and confronting issues that need to be addressed (Interviews 1-5, 2000, 2001, Gallant, p. 72). During a group session, group leaders have to challenge and confront members; they are instrumental in pointing out when members turn to blaming, and must be on hand to ask members how they feel, so they can steer them back on track (Interview 4 & 6, 2001).

The role of group leader is very interactive and is viewed as a team approach. Group leaders often act as trouble shooters if an incident occurs, which may require the assistance of other group leaders to cover the facilitation of group meetings, oversee a meal, or take incoming phone calls (Interview 2, 2000).

Alumni

The friendship and support that individuals and their families find at Brentwood while on program continues after treatment is completed. Some clients continue in an outpatient and/or day care setting. Graduates of the Brentwood program are encouraged to attend 2-3 meetings per week to ensure a successful recovery process. If they live out of town, and cannot return to Brentwood, they are advised to go to A.A. (Interview 2, 2000). Alumni and their families are encouraged to help these graduates continue with their sobriety, and are assisted by Brentwood staff through supportive counselling. The belief is that “the program was here for me, so I need to be here for the new people coming in” (Interview 2, 2000). Therefore, alumni are a vital part of the treatment team.
Recovered alcoholics are involved in every aspect of Brentwood's operation, including membership on the Board of Directors, on their staff and in their Counselling programs. They help the clients regain control of their lives and encourage them to become aware of their potential ability to cope with the demands of independent everyday living. The staff at Brentwood rely on the alumni "to come back to help the new people and share their experience, give hope, and show that it does work" (Interview 4, 2001).

Special programs are designed for alumni and their families to help ensure continued sobriety (Gallant, 1992, p. 2). Brentwood puts on many activities for alumni and their families to ensure they remain part of the fellowship. Some of these activities include dances, picnics, and alumni retreats (Interview 4, 2001).

**Theme of the day/week**

Fr. Paul speaks daily to the members, staff and alumni at Brentwood. His talks are typically twenty minutes long, and all members are required to attend. The talk that Fr. Paul gives sets the tone for the day/week. Depending on the topic Fr. Paul chooses to address, the theme may carry forward for the entire week. The theme is addressed and highlighted in each of the group meetings as well as the members' journals.

Gallant (1992) states that Fr. Paul's talks are a "powerful medium for achieving the basic goals of recovery and for enhancing the spirit of community" (p. 38). Gallant states that a consistent message can be found in the daily talks; "people are the children of God and have within them the capacity to choose a better way of life, progressing from bondage to freedom" (p. 38). This progression occurs in and through other people, and a
statement frequently given during the course of the interviews that were conducted is that
Brentwood is founded on the principle of people needing people. “Brentwood is proven
successful for people of various backgrounds because it’s not about religion; it’s about
people needing people (that’s spirituality). It’s about forgiveness of yourself, and
learning to develop trust and respect for other people” (Interview 2, 2000). Another
group leader who was interviewed stated, “recovering alcoholics need other people; it’s
the only way to get through” (Interview 4, 2001).

The following excerpt was taken from Dr. Gallant’s 1992 book and provides a
brief glance at Fr. Paul’s message of recovery that is demonstrated through his daily talks
at Brentwood. Taken individually, these themes serve as topics of discussion for each
day or week.

P  Problem recognition and resolution
E  Experiencing the need for other people
O  Open to confiding, consulting and accepting direction
P  Positioning oneself to listen to others and their concerns
L  Learning to think, feel and behave responsible
E  Expression of self in an other-directed manner

N  Needs of the individual being met: The spiritual
E  Examining the language of the heart and the emotions
E  Emotional balance, security and confidence
D  Discipline and responsibility
I  Internalizing mature adult values
N  Needs distinguished from wants
G  Gratitude for a valued growth experience

P  Participating meaningfully in the life of family and community
E  Enhanced energy level and zest for life
O  “One with” the self and “one with” others: A must
P  Peace, forgiveness and joy
L  Love, understanding and patience
E  Enhanced cooperation and socialization
After Fr. Paul speaks on an individual topic, a staff member shares a story or experience that relates to the topic. Members then break out into their home groups and everyone shares their thoughts and feelings on the topic, at whatever level they are capable of at that time (Interview 1, 2000).

**Commitments**

Members gather at 9:30 am each day in the main meeting hall to make their commitments. The seats are arranged in a horseshoe shape with the men sitting on one side of the horseshoe, and the women on the other. A staff member enters the meeting hall and the members on program are silent. The large group is split into smaller ones, based on the home group each person was assigned to when they were first admitted to Brentwood. The home groups are usually clustered together in pairs, and each pair of home groups is assigned to a different area of the facility to break off, and make their commitments for the day. Since this group session is only thirty minutes long, a group leader calls on members to stand and share the commitment they are going to make for the day.

The program, as a whole, encourages members to focus on how they can better themselves and part of that introspection includes deciding on one action each day that they can undertake for the good of themselves. Once the member states what the action is, they must also say why they have chosen this particular action, and how they will carry it out. Commitments that members make may include: being honest, being kind, and working their program.
Philosophy

“The problem of addiction is the inability to truly love or be loved. All problems stem from this” (Interview 6, 2001). The addict is powerless, and is unable to handle their life in a responsible way, their addiction is the outlet (Interview 6, 2001).

Brentwood is a basic program. Its philosophy is very simple; it’s about the self, and looking inside your self to work towards recovery (Interview 4, 2001). Brentwood is dedicated to a teamwork concept, which is exemplified in a spirit of cooperation, integrity and fellowship. According to Gallant (1992), human spirituality is the underlying assumption of the Brentwood philosophy and alcoholics need to learn basic fundamental spiritual principles (p. 63). Consistent with Brentwood’s philosophy, there is a social and ethical commitment to youth, the community, and society at large (www.brentwood.on.ca). Brentwood’s vision is to provide a secure, healing and hope-filled environment. The Brentwood group leaders claim that the aim of the programming is designed to enable residents to get back their dignity, self-respect, freedom and trust (Interviews 1-5, 2000, 2001).

Spirituality

At Brentwood spirituality is an “indispensable belief, which maintains that people need one another for their growth and fulfilment. The spiritual communicates a language of the heart and is personified by mutual understanding, shared compassion, caring confrontation and reciprocal growth. The strength, unity, balance and wisdom which is derived from fellowship are all spiritual ingredients which are generously experienced at Brentwood on a daily basis” (Gallant, 1992, p. 202).
Gallant (1992) states that the staff at Brentwood view alcoholism as a spiritual disease, with emphasis placed on the personal and social ramifications of this "spiritual affliction." Alcoholism is therefore seen as an ailment that not only threatens others, but also alienates the alcoholic from the self, the real world and from God and nature (p. 4). Gallant says that the program's spiritual dimension includes a cosmic, ecumenical and Judeo/Christian perspective. This approach is the one taken for all residents regardless of their social, economic, racial, cultural, educational or religious background (p. 30). "Recovery is about human stuff, it's not about difference, and not about religion. Being spiritual is not about God, being spiritual is people caring about other people" (Interview 1, 2000).

The notion that spirituality is separate from, and in this context, more important than religion, is an example of the discourse of inclusiveness that underlies the Brentwood program. The Brentwood philosophy supports this discourse of sameness by promoting spirituality above all else, and claiming that the program can work for anyone regardless of their background, religious or otherwise.

The group leaders at Brentwood believe that because it is a spiritual program the more people it has, the more successful the program can be. Fr. Charbonneau feels that the size of the group provides the members with the chance to leave their own narrow world of preoccupation and give themselves genuinely to someone else (Gallant, 1992, p. 79). Each new person that comes into the facility adds a different dimension to the group setting. The more people who are 'on program,' the more diverse the stories and experiences tend to be. When members are exposed to a variety of painful, and often humiliating, stories, they are more willing to open up, and share their own experiences
with the group. The comfort that comes from hearing other stories that are either similar to your own, or more shameful and humiliating, is what leads many of the members to the belief and understanding that they are not unique, and as long as they are free to open their closed hearts, they will begin their road to recovery (Interview 2, 2001).

Gallant notes that a key ingredient to the Brentwood model is Fr. Paul’s charismatic nature, his talks, and how he instils into the fellowship the spirit of caring, sharing and acceptance (p. 62). When Fr. Paul gives his daily talk, regardless of what the topic is, all eyes in the room are focused on him. He doesn’t just stand at the front of the room, lecturing to the group, but rather walks between the rows of people, and moves from the front to the back as he talks. Staff and members seem to hang on every word he says. Both staff and members suggest that their attention to Fr. Paul’s talks comes from the respect they have for Fr. Paul, as well as, the recognition of his experience with, and commitment to, the recovering alcoholic.

The spiritual model on which the program is built, as well as the specific manner in which the various elements of sharing, confiding and consulting are expressed and interwoven, make it unique (Gallant, 1992, p. 64). The group leaders who were interviewed at Brentwood believe that the alcoholic centers life on himself: they are so self-involved, that they often don’t realize how many people they have hurt (Interview 4, 2001). This is why the sharing component of this program is so important. “Sharing how an alcoholic has hurt others is the key thing, it makes them look at themselves, and feel what they’ve done, and it makes them have feelings” (Interview 4, 2001). Learning how to access your feelings is one of the core components of this program.
The five group leaders who were interviewed for this project had very similar thoughts on the topic of spirituality at Brentwood. All of them felt that being spiritual is not about God; it’s people caring about people. When asked ‘what role does spirituality play in the programming that is offered at Brentwood?’ they responded, “It’s everything.” Each interviewee communicated that spirituality is the umbrella that everything else falls under. It is the foundation of the program (Interviews 1-5, 2000, 2001). “The alcoholics’ affliction is the inability to love and receive love. The simplicity of the program and its spiritual foundation forces individuals with addictions to look inside themselves and recognize that they have feelings, they need to get in touch with these feelings, and allow others to touch them, if they want to join the path to recovery” (Interview 4, 2001).

As mentioned previously, the organizational characteristics of the Brentwood program, including its reliance on many of A.A.’s Twelve Steps and Twelve Traditions, make the Brentwood model, in many ways, comparable to A.A.’s treatment approach. More specifically, Brentwood maintains the position that above all else, to achieve sobriety, an alcoholic must have the desire to stop drinking. This coincides with A.A.’s third tradition. Parallels can, and will in the analysis section of this paper, be drawn between Brentwood and many of A.A.’s Twelve Steps. Generally, Brentwood’s program is closely attuned to steps one, two and four. These steps include issues such as: admitting you are powerless over alcohol, acceptance of a higher power, and searching your inner self for the wrongs you have committed.

This chapter has reviewed the organization, philosophy and programming components that make up Brentwood Recovery Home. Given the similarities between Brentwood and the A.A. model, this chapter has brought to life what has been stated in
the previous discussion of Alcoholics Anonymous. Like A.A., Brentwood’s program is rooted in the discourse of sameness. Members of Brentwood’s fellowship promote the program as suitable for anyone because “all alcoholics have the same needs.” (Interview 1, 2000).

While many of the previously mentioned treatment methods are apparent in Native recovery centres, the inclusive discourse of A.A. and Brentwood is in contrast to Native programs, where the recovery model stresses difference. The discourse of difference, grounded in exclusiveness, will be introduced in the following chapter and further discussed in the analysis section of this paper.
CHAPTER VI

Native Recovery Programs

This chapter discusses the salient features of recovery programs designed specifically for Aboriginal people to outline the ways in which the treatment approaches permit a degree of ‘cultural space’ that allows for the incorporation of distinctiveness. To further this investigation, parallels will be drawn between Native treatment programs, A.A. and a non-Native treatment facility. The data used for this comparison was collected primarily from 53 websites and while similar information was derived from a variety of sites I recognize that any statements made or conclusions that are drawn based on website information must be considered limited.

The National Native Alcohol and Drug Abuse Program (NNADAP) will be reviewed along with the facilities it sponsors. In addition, Native treatment facilities that are not governed by this initiative will be discussed. An overview of “culturally specific” treatment methods, as outlined in contemporary literature, will also be provided.

According to Coyhis (2000), the sobriety movement within North American Native communities began to gather force in the mid to late 1980s (p. 78). Today, awareness of substance abuse within Native and non-Native communities have increased dramatically, and so has the availability of “culturally specific” treatment programs. Coyhis states that using one’s culture as an adjunct to recovery provides the individual with an ally that may help unlock emotional energy in the service of sobriety (p. 79).

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5 The NNADAP is a government initiative that operates under the authority of the First Nations and Inuit Health Branch, an arm of Health Canada. The program rests on the assumption that effective community programs will decrease the need for in-patient treatment services.
In Canada, there are approximately 60 First Nations and Inuit Health programs that target substance abuse, whether it is drugs, alcohol, or solvents. These treatment facilities are listed in the Directory of National Native Alcohol and Drug Abuse Programs (NNADAP). (www.hcsc.gc.ca/msb/fnihp/NNADAP_PNLAADA/directory_e.htm). The NNADAP was established to provide support for First Nations and Inuit people and their communities by establishing programs aimed at arresting and offsetting high levels of alcohol and substance abuse among target populations. NNADAP sponsored programs include: prevention, treatment, training, research and development, family violence and community health representatives (http://ccsa.ca/mckenzie.htm). According to the NNADAP directory website, most of the treatment facilities offer some type of cultural activity as part of their recovery program. The “culturally specific” treatment activities appear to be offered in addition to the non-specific programming one would see in any addictions facility, for example, assessment, alcohol and drug education, group counselling and an A.A. approach to recovery.  

Native Treatment Facilities

In this section I will outline some of the NNADAP sponsored and non-sponsored treatment facilities to provide a summary of the treatment components that are offered. This overview will illustrate the level of comparison that can be made with non-Native recovery programs.

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* In addition to government sponsored and non-sponsored Native treatment programs, there is also a branch of Alcoholics Anonymous that was established to service Native people in North America. This organization is called the Native American Indian General Service Office of Alcoholics Anonymous (NAIGSO) See Appendices E and F (http://www.naigso.org/index.html).

53
Poundmaker’s Lodge is a well-known Native treatment centre on the outskirts of Edmonton. It was founded in 1973 and named after a Cree chief who was wrongly imprisoned for taking part in the Riel Rebellion (Maracle, 1993, p. 196). The lodge is a 30-day stay facility that was designed as a refuge for Native peoples lost in a world of alcohol and drugs. According to a documentary produced by the National Film Board of Canada (1994), Poundmaker’s Lodge: A Healing Place, staff members at the lodge intend to facilitate the healing process by instilling a sense of belonging to Natives who often feel displaced, not welcome in the city, or at home on the reserve.

It is the hope of those who run the lodge that this sense of belonging will be introduced to those who seek out help by using traditions to heal. A common theme expressed by various individuals who were interviewed in the film was the feeling that they had no identity. Many of these Native people spent their youths in foster homes, often with white families, and when it was time for them to leave, some tried to return home and were rejected because they embodied “white ways.” One of the main goals of Poundmaker’s is to teach Aboriginal substance abusers how to regain, and retain their own culture, beliefs and values. Maracle interviewed an addictions counsellor trainee for his book “Crazywater” (1993), who described Poundmaker’s Lodge as a place for healing people, a place to bring up their spirit and help them understand themselves as human beings (p. 196).

The goal of the Poundmaker program is abstinence through counselling, peer support, information, and opportunities for spiritual growth. The program’s core structure consists of four treatment components; education, skills development, counselling, and Native culture, with Alcoholics Anonymous playing a strong role. The
mission of Poundmaker's is to achieve and maintain a life of sobriety. Supporters of this program believe that Alcoholics Anonymous and Narcotics Anonymous have the greatest capacity to help addicts develop this desired way of life.

(www.gov.ab.ca/aadac/services/specialized/poundmakerNative.htm). It is important to remember that Poundmaker's Lodge is unique because it is the only Native alcohol and drug treatment centre found through this research that is funded, managed, and staffed solely by Native people.

Poundmaker's is the largest facility that I found documented in the literature; however, other lodges and recovery programs do exist. The Bonnyville Indian Metis Rehabilitation Centre is a smaller facility whose program content includes; an introduction to A.A., individual counselling, group counselling, films, lectures, workshops with the Elder, Native culture, and recreation. The Barrie Native Friendship Centre is another smaller facility with similar programming including individual and group counselling and treatment referrals to “culturally appropriate” treatment centres for Aboriginals, Inuit and Metis with substance abuse problems. New Directions is a Treatment Centre located in Ohsweken, and provides educational programs and counselling on an outpatient basis for First Nations people affected by the use of alcohol or other drugs. The Can Am Centre, located in Windsor, Ontario, offers employment

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7 When discussing Native treatment facilities, the term Elder often arises. Elders are the guardians of culture and history and have wisdom and life experiences, which can benefit the community. Not every older person is an Elder. It is a position of respect and recognition conferred upon those the community looks to for guidance. Elders are both men and women, and have different ‘gifts.’ Individuals seeking spiritual assistance will choose an Elder on the basis of their needs of an Elder’s gift (Orchard as cited in Spiteri, 1998, pg. 18).
services, pre-natal care, health outreach, Alcoholics Anonymous, individual
counselling, drumming, and traditional teaching camp (Interview 7, 2001).

Similar to Brentwood and A.A., Native programs appear to differentiate between
spirituality and religion. In Native communities, a spiritual approach to recovery may be
associated with Earth or Nature. According to Coyhis (2000), culture is an expression of
spirituality; therefore culturally specific treatment programs must have a firm grasp on
the spiritual world (p. 85).

It has been my experience, through reading literature, and attempting to contact
members of the Native recovery community, that non-Native members do not easily have
access to the teachings used in “culturally specific” recovery models. It has been
suggested that this is due to the nature of the delivery of these teachings. Native
teachings are traditionally presented using oral communications through talks,
discussions, talking circles and ceremonies (Coyhis, 2000, p. 79). The use of narratives
in Native treatment models may influence the entry of cultural values and ideals into the
programming that is offered. The use of narratives by Native treatment facilities creates
spaces whereby program participants are free to use their own sense of the world to
subjectively address their addiction and personalize their recovery. In this context,
treatment is about more than just alcohol; it may enable individuals to embrace
“tradition” and learn about their “culture.”
Discourse of Difference

Discussions of “culturally specific” methods of treatment often refer to treatment components such as sweatlodges and healing circles. These are methods of recovery that stress difference rather than inclusiveness. The medicine wheel, sweatlodge, smudging and use of the eagle feather will be reviewed to illustrate the language of distinctiveness employed in “culturally specific” treatment.

Coyhis (2000) states that the Medicine Wheel is an ancient way of teaching that is premised on the circle. It is a way of sharing knowledge and information that are in harmony with the methods the Great Spirit implemented long ago (p. 89). According to Coyhis, we live in a system of opposites, and the Medicine Wheel teaches Native people how to put that system into place (p. 89). Teachings of the Medicine Wheel can be applied in many facets of life, but from a recovery standpoint, it is the four directions of human growth that are represented in the circle that are of greatest importance. These four directions are emotional, mental, physical and spiritual (Coyhis, p. 89).

The importance of the human growth directions is related to balance. Coyhis (2000) states that for the Native substance abuser to begin recovery, they must take a personal inventory, and determine which directions they are lacking. Typically it is the spiritual and emotional directions of human growth that are in need of healing. In order to fix this imbalance, one must look inside them to determine what is going on with their own system, and decide on the necessary steps to attain balance. Coyhis goes on to suggest that once an individual has worked with the four directions, they can find their place of harmony and achieve what is necessary to recover (p. 92).
In addition to the Medicine Wheel, the Sweatlodge is cited as another “culturally specific” mode of treatment that appears to be used by some Native facilities as part of the recovery process. The Sweatlodge is the symbol of purification; it represents the beginning for those who believe in its healing powers. “People are reborn in the Sweatlodge just as they are reborn when they give up alcohol (http://poundmaker.org/mission_and_philosophy.htm).” The Sweatlodge is circular, and the people who participate in the ceremony sit in a circle. The doorway of the Sweat lodge faces east, which is the symbol of new beginnings.

The burning of sage, sweetgrass or other herbs is called “smudging.” It is traditionally used to prepare and purify a person, place, or thing for a time of openness and truth the presence of our Creator. Prior to group meetings the room is smudged. The sage is passed around the circle for each person in the circle to smudge. If they prefer not to they pass it on to the next person in the circle.

Praying with an eagle feather is said to accelerate a person’s shift in awareness, and changes will start to happen (Coyhis, 2000, p. 102). Coyhis states that the eagle feather has many teachings. Long ago, it was believed that the eagle carried prayers to the Creator because it flew so high in the sky. That belief is the basis of the importance of the eagle feather and the reasoning behind why it is so highly respected (p. 102). When the eagle feather is passed around at group meetings, a person may choose to hold it or let the person next to them hold it while sharing. The eagle feather is also smudged before use.

A further caution is necessary. The discourse on Aboriginality does stress difference and provides support for the need of a distinct mode of care. However, the
fact that this discourse is broadly conceived and inclusive should not lead us to believe
that Aboriginal people constitute a homogeneous group. Therefore, we cannot assume
that the practice's described necessarily occupy the cultural space available in treatment
facilities. Instead, we should recognize that more specific, local cultural differences are
likely to come into play.
CHAPTER VII

Analysis

Introduction

Current literature on alcoholism in Native communities suggests that substance abuse is a result of the contemporary history of socio-economic conditions among Native people (Maracle, 1993; Scott, 1992; Whitehead & Hayes, 1998). These authors suggest that alcohol abuse may function as a coping strategy for poverty, unemployment, poor health, negative residential school experiences and other imposed actions, which serve to break families apart, or relocate whole communities. Substance abuse has been described as a manifestation of the ‘alienation’ of Aboriginal peoples, whereby their traditions and styles of life are significantly different from, and not accommodated by the patterns of Canadian society. Kim Scott’s (1992) research furthers this discussion in a specific way by itemizing the reasons that Native people have given for substance use or abuse. Respondents ranked pre-determined factors in order of importance. The most important factor indicated was loss of cultural identity.

Some Native leaders see the survival of language and culture, and therefore identity, as dependent upon the maintenance and continued development of their “distinct societies” (Durst, 1995, p. 7). A primary aim for Native peoples has been to achieve greater local control over their communities, and to recodify their status and rights, politically and legally, within society.

Various scholars (Maracle, 1993; Whitehead & Hayes, 1998) suggest that the need for separate substance abuse treatment facilities rests on the longing of Aboriginal
people to return to a more "traditional" way of life, in hopes to regain something that has been lost. The expressed interest in returning to "earlier forms of life" is related to the desire to attain and maintain a distinct social identity (Morris, 1988, pg. 73).

The state’s response to this request was to establish a governing body with the intent of transferring the authority to manage health care programs and resources to Indigenous groups. Thus, Health Canada suggests that the First Nations and Inuit Health branch will cultivate a relationship with Native communities based on the transfer of health services, and a concentrated federal role that seeks to enrich the health status of Native peoples (www.hc-sc.gc.ca/fnihb/index.htm). This arm of government oversees the National Native Alcohol and Drug Abuse Program (NNADAP) that was founded in 1987 to provide support for First Nations and Inuit people and their communities by establishing programs aimed at arresting and offsetting high levels of alcohol and substance abuse among target populations. Approximately sixty NNADAP sponsored programs exist across the country to serve the Native population. These programs turn the responsibility for Native recovery programs over to Native community leaders and health care workers, emulating the government’s support of cultural pluralism.

Rose (1999) states that technologies of government can be transformed shaped and applied (p.52). I suggest that Federally-sponsored Native treatment programs are technologies of government that are imbued with aspirations for shaping the conduct of individuals in the hope of producing certain desired effects and averting certain undesired events (Rose, p. 52). Despite their acknowledgment of cultural differences the treatment approaches used in Native recovery facilities are derived from the inclusive model of A.A.
In chapter seven it was shown that the A.A. model is applied in Native treatment facilities. In this chapter the question raised is how a therapeutic model that downplays the significance of difference can be employed in a way that recognizes the importance of cultural difference. I argue that application of the A.A. model, despite the emphasis on sameness, allows the incorporation of difference into the treatment process. Native facilities recognition of distinctiveness creates cultural spaces that allow treatment to be applied in a less inclusive way.

A second and related issue that will be considered is the impact of the Federal government's desire to renew their relationship with Indigenous peoples through the shift in authority of selected services from government agencies to Native communities. This question will be explored in a general way to suggest that the renewed relationship between the Federal government and Indigenous groups may be seen as a strategy of governance. According to Rose (1999) governance is neither a concept nor a theory, but a perspective. It can be seen as good or bad. Good governance means less government, whereby “politicians exercise power by steering or setting up policy, rather than rowing or delivering services” (p. 16).

These issues will be addressed through a comparison of the “philosophies” found within A.A., Brentwood and Native programs. This will include a discussion of the nature of fellowship, spirituality, and the idea of holistic treatment. At this level of analysis, comparisons can be drawn with respect to information available in the literature and websites, as well as the selective use of interview material. Attention will also fall on what can be called the “structural components of the treatment programs.”
By this I mean the use of groups, the sharing of stories and the incorporation of A.A.'s general values.

There will also be a discussion of one of the key features of the A.A. treatment approach. Specifically, this refers to the “sharing of stories” in the context of small groups. Again, parallels can be drawn from the literature and websites. However, in addition to this an analysis of the practices followed at Brentwood provide some insight into the cultural space made available in the treatment process that could be utilized in a program that emphasizes the importance of cultural difference.

**Philosophical Similarities**

The use of A.A.’s fundamental values and beliefs is an organizational tenet that will be examined for the purpose of this comparison. The twelve steps of A.A. are at the core of the A.A. program. According the groups website, the steps are not abstract theories, but are based on the trial and error activities of early A.A. members (http://www.alcoholics-anonymous.org). The “official” position of A.A. is that the steps are absolutely necessary if alcoholics are to maintain their sobriety.

Brentwood’s use of A.A philosophies is quite clear. However the program’s use of the twelve steps is not as direct. Group leaders state that twelve steps are not literally examined, but they are all adopted in practice (Interviews 3, 4, 2001). A clear connection can be drawn between three of A.A.’s twelve steps and components of the Brentwood program.

The first of A.A.’s twelve steps involves admitting you are powerless over alcohol. This initial step is necessary for abstinence based treatment programs and the
Brentwood is no exception. Members on program at Brentwood are required to stand during group meetings and state “I am an alcoholic.” This admission is a sign that the individual has recognized their addiction and is willing to take steps to turn their addiction around. Brentwood’s commitment meetings, as described in chapter five, are derived from the third step of A.A. that states, “make a decision to turn your will and your life over to the care of God as you understand him” (Jensen, 2000, p. 52).

Lastly, the inventory meetings conducted at Brentwood are derived from the fourth step of A.A. that states, “make a searching and fearless moral inventory of yourself” (Jensen, 2000, p. 54). Members are required to keep daily journals where they are encouraged to reflect on stories, situations or accounts that they are ashamed of, or would like to change for whatever reason. These journals are then shared during inventory meetings (Interview 1, 2000, Observation, 2001).

The literature is separated into two schools of thought on the effectiveness of integrating Alcoholics Anonymous into Native recovery programs. The first group suggests that although A.A. works for some Native people, those who were raised with “traditional” teachings may struggle with the inclusivity of the fundamental philosophies of the A.A. model (Coyhis, 2000, p. 81).

The second school of thought suggests that A.A. philosophies and practices can be successfully integrated into existing Native programs if they are modified to incorporate “traditional” teachings as well. In this view, the twelve steps of A.A. can become more valuable to a Native person when the whole twelve-step program is positioned in a “culturally specific” context. According to Coyhis (2000), elders have stated that if an individual understands the 12 steps in a ‘Native way’, they’ll find that
they are in alliance with “traditional” Native values (p. 103). Coyhis further states that the 12 steps can be utilized in a “culturally specific” way by bringing the steps into alignment with circle thinking and the Medicine Wheel.

In order to use the twelve steps in a culturally specific way, the wording needs to be altered. One Native author, as an alternative to A.A.’s twelve steps, has outlined the following:

**Step 1 Honesty**
We admitted we were powerless over alcohol – that we had lost control of our lives.

**Step 2 Hope**
We came to believe that a power greater than ourselves could help us regain control.

**Step 3 Faith**
We made a decision to ask for help from a Higher Power and others who understand.

**Step 4 Courage**
We stopped and thought about our strengths and our weaknesses and thought about ourselves.

**Step 5 Integrity**
We admitted to the Great Spirit, to ourselves, and to another person the things we thought were about ourselves.

**Step 6 Willingness**
We are ready, with the help of the Great Spirit, to change.

**Step 7 Humility**
We humbly ask a Higher Power and our friends to help us to change.

**Step 8 Forgiveness**
We made a list of people who were hurt by our drinking and want to make up for these hurts.

**Step 9 Justice**
We are making up to those people whenever we can, except when to do so would hurt them more.
Step 10 Perseverance
We continue to think about our strengths and weaknesses and when we are wrong we say so.

Step 11 Spiritual Awareness
We pray and think about ourselves, praying only for the strength to do what is right.

Step 12 Service
We try to help other alcoholics and to practice these principles in everything we do. (Cohyis, 2000, p. 103,104).

Cohyis believes that altering the wording of A.A.'s Twelve Steps so that they appear more relevant to Native groups will allow the steps to be incorporated into Native treatment programs. Although substituting words like God for the Great Spirit has altered the wording of the steps, the meaning of the steps sounds relatively the same as A.A.'s original version. In this respect, it may be noted that the term “great spirit” can be generally constructed to encompass the religious beliefs found among Native peoples.

The previous chapters have shown that NNADAP sponsored programs, along with programs such as Poundmaker's Lodge use A.A. and its fundamental philosophies in the same way that they are used at Brentwood Recovery Home. At Poundmaker’s Lodge, the program is said to consist of four treatment components; education, skills development, counselling, and Native culture, with Alcoholics Anonymous principles playing a strong role. This is illustrated through many comments on the facilities website, including, “because there is no single source available with a greater capacity for helping alcoholics develop and maintain a life of sobriety, A.A. plays an important role in the Poundmaker’s Lodge program” (http://poundmaker.org/mission_and_philosophy.htm).
The Can Am Centre offers employment services, pre-natal care, health outreach, individual counselling, drumming, and traditional teaching camp (Interview 7, 2001). In addition to these services, alcoholics who come to the Can Am Centre are strongly encouraged to attend local A.A. meetings. It has been said that until something more appropriate is developed for this area, A.A. is the only option for alcoholics (Interview 7, 2001). Although the Can Am program is not sponsored by the NNADAP, it is federally and provincially funded, which allows the government to maintain some authority over the operations of the program. I suggest that this method of governing is a form of self-determination in which the Federal government retains financial control. This argument is in line with Rose (1999) who states “to govern humans is not to crush their capacity to act, but to acknowledge it and utilize it for one’s own objectives” (p. 4).

Many of the programs outlined in the NNADAP directory cite Alcoholics Anonymous as a principle treatment component. My initial thoughts were that A.A. principles were being modified in Native treatment facilities so that the fundamental philosophies were positioned in a “culturally specific” context. The information available from NNADAP facilities suggests otherwise. A.A. ideology appears to be literally transmitted, including the use of A.A.’s Big Book, from non-Native recovery programs to facilities designed for Native people (www.hc-sc.gc.ca/fnihb/chp/n…/treatment_centres/beaver_lake.htm). A.A. may be very effective for some, Native or otherwise. However, it is misleading to suggest that the treatment technologies used by Native recovery facilities are markedly different from non-Native treatment approaches, specifically Brentwood and A.A. The following section will discuss the underlying philosophies of A.A., Brentwood and government-sponsored
Native treatment programs. More specifically, similarities will be drawn out based on the importance of fellowship together with spirituality, and the value of holistic treatment.

As discussed in the chapter on Alcoholics Anonymous, the notion of fellowship has been critical from the program's inception. In the beginning, A.A. consisted of talking to, helping and maintaining contact with other people who were unable to control their drinking. Early members of A.A. were also required to participate in some form of spiritual activity, which initially consisted of attending local Oxford Group meetings (Makela et al., 1996, p. 19).

The fellowship quality of A.A. began with one alcoholic wanting to take a drink, and seeking out another in the hopes that such support would help suppress the desire. The two men soon realized that the support they received from each other was critical to their sobriety and began to work with other alcoholics at a local hospital. The idea of a support network, or fellowship, has been embedded in A.A. philosophy across time. Two of A.A.'s twelve traditions reflect the importance of maintaining the fellowship, stating that: "...personal recovery depends on A.A. unity and that each group has but one primary purpose — to carry its message to the alcoholic who still suffers" (http://www.alcoholics-anonymous.org). Little has changed since the 1930s; the idea of one alcoholic helping another remains the foundation of the program. However, today A.A. members can choose their own spiritual direction and affiliation.

Alcoholics Anonymous is a recovery movement that has persisted through time. Consequently, its ideals and philosophies have been integrated into a variety of programs and services. The idea of fellowship is a model that has been implemented by the
treatment programs evaluated in this project. The emphasis and importance of spirituality is directly related to the fellowship model.

Once you enter Brentwood, it is your fellowship, and this concept of fellowship transmits directly from A.A. (Interview 1, 2000). The programming offered at Brentwood revolves around the notion of “people caring about people, and people needing other people” (Interviews 1, 2, 2000 & 3, 2001). The phrase “closed heart” is one that is often used during group discussions. The idea of a closed heart centres on the notion that alcoholics have shut down emotionally. In order to begin recovery, alcoholics must learn to get in touch with their feelings and open up to other people (Observation 2001). The group leaders interviewed state that another alcoholic is the only one who can understand the feelings that arise during this process; understanding these feelings, and helping someone deal with them is the fellowship aspect of the program (Interviews 1-5, 2000, 2001).

Spirituality is said to be the foundation of the program. At Brentwood, spirituality is about the human spirit, and looking inside yourself for answers to why you drink (Interview 3, 2001). The group leaders interviewed claim that a misconception exists where people who are not involved in the program believe that treatment revolves around religion. They state that the program, and spirituality in general, is not about God; rather it’s about examining your life to regain balance and become a fully functioning person through recovery (Interviews 1-5, 2000, 2001).

Native treatment programs appear to hold many of the same fundamental beliefs that have been carried over from A.A. philosophies. The aim of many Native programs is to enable participants to acquire balance in their lives. Balance is attained through
sharing and sharing means helping others (Interview 7, 2001). Sharing in Native facilities is premised on the circle. If you recall from the previous chapter, the four directions of the circle are emotional, mental, physical and spiritual (Coyhis. 2000. p. 89). Similar to Brentwood, it is an alcoholic's emotional and spiritual part of their inner circle that is need of healing (Interview 7, 2001). Healing occurs through group discussions with other alcoholics, this is the nature of fellowship in Native treatment programs.

As with Brentwood, the information on Native programs suggests that spirituality is crucial to successful recovery. In line with the rationales of the Brentwood program, many Native facilities assert that it is the belief in the spiritual that will lead a person to recovery, and the belief in the spiritual does not mean the belief in a specific religion (Interview 7, 2001). Spirituality and balance are explicitly intertwined; they are both about human growth and being in tune with your internal system. Once you assess what is off balance you can begin to take the necessary steps toward recovery (Coyhis. 2000. p. 92).

Brentwood and Native treatment facilities seem to rely heavily on their fellowships to aid members in the process of recovery. This finding was expected since the development and maintenance of a fellowship are of utmost importance in the Alcoholics Anonymous paradigm that the two former types of treatment ideologies have been modeled around. The importance of spirituality to recovery has also been highlighted as a philosophy that extends from A.A. to Brentwood and Native treatment programs.

Spirituality is another component of Brentwood and Native programs that appear to be premised on essentially the same grounds. Spirituality, in this case, is about looking
inside yourself to determine how you can restore balance to your life and begin the road to recovery. It will be recalled from chapter four, spirituality was a key component of the original A.A. program, suggesting that the ways the treatment is described at Brentwood and in Native programs emphasizes that the importance of spirituality is an additional similarity between the three treatment approaches.

The parallels drawn out here were intended to highlight similarities with respect to the notion of fellowship, reliance on, and definition of, spirituality. These connections further support the belief that many Native recovery programs are not entirely unique, “culturally specific” treatment facilities, but are rather an expression of existing treatment technologies that appear to provide limited space for subjectivity and recognition of distinctiveness. The methods by which the treatment is described and the ways in which it is practiced may be open to interpretation.

The final philosophical tenet that will be outlined for this comparison is the importance placed on the holistic treatment of alcoholics. In using the term holistic I am referring to the rationale that suggests that recovery is not just about getting sober, it is about looking at the alcoholic’s entire life.

At A.A., the local group meeting is the core of the program. The literature on Alcoholics Anonymous makes it clear that to attain and maintain sobriety it is necessary to include people close to you in your treatment. Open group meetings encourage members, and newcomers in particular, to invite husbands, wives and friends for their support. The philosophy rests on the assumption that relative’s and friend’s understanding of the recovery program may be an important factor in helping the alcoholic to achieve and maintain sobriety. In some cases, husbands and wives attend as 71
frequently as their spouses and take an active part in the social activities of the local group (www.alcoholics-anonymous.org). There are also groups that have been formed as extensions of A.A. like Al-Anon and Al-Teen.

Since Brentwood is a residential program, it is not possible for family members to be as involved in day-to-day group meetings. However, when requests are made, Father Paul individually counsels families in need (Interview 4, 2001). The belief is that one person alone cannot pursue recovery. Although the alcoholic must make a personal commitment to the program, it is said to be critical that they have the support of people close to them (Interview 2, 2000). Whether or not this is true in practice is unknown.

Brentwood staff and members plan many social activities so that members on program can maintain connections with their family while they are in treatment. Family picnics are arranged during the summer months, dances are held all year round and alumni retreats are scheduled twice a year (Interview 4, 2001).

Alcohol treatment programs for Native people often include services that are designed to help the alcoholic in every aspect of their life. These services may include employment counseling, pre-natal care, literacy programs and crisis intervention (Interview 7, 2001, www.hc-sc.gc.ca/msb/fnihp/NNADAP). The rationale given for offering these services is the same as A.A. and Brentwood. Recovery from alcoholism cannot be undertaken without the support of those around you, and without addressing weaknesses in all aspects of your life (Interview 7, 2001). One stage of recovery in many Native treatment programs appears to be the renewal of family relationships. This includes becoming involved with family and community activities and re-establishing emotional ties with supportive family members(www.thewisdomkeeper.com/drugs.html).
Evaluating A.A., Brentwood and Native recovery programs on the basis of the holistic treatment model adds another dimension to the discussion of treatment technologies. The importance of family support is obvious in an examination of Alcoholics Anonymous, Brentwood and Native Recovery programs. The similarity in this level of recovery further supports the notion that Native treatment programs are modeled after the A.A. approach to recovery.

**Groups/Narratives**

In my research I found that one of the greatest similarities in addictions treatment, regardless of the target population, is the use of small groups. In A.A., Brentwood, and Native treatment programs the formation of groups for the purpose of pointed discussion appears to be a common practice. The programs reviewed in this study revolve around the sharing of stories with other alcoholics and group leaders in an effort to look inside oneself for the truth that led them to drink. It is believed that this search for truth can only occur with the help of other alcoholics; this is the nature of fellowship.

In Alcoholics Anonymous, the local group is the heart of the A.A. fellowship. There are two types of local meetings, open and closed. Customarily, the speakers at open meetings are A.A. members. New members are invited to share their story that led them to join A.A., along with what sobriety has meant to them. Closed meetings are limited to members of the local group, or visiting A.A. members from other groups. The sharing that occurs within these meetings is structured to focus on designated phases of alcoholism. Supporters of A.A. believe that these phases can be best understood and supported by other alcoholics, and that it is difficult to begin and maintain recovery.

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without the support of those with similar experiences that can be shared and drawn on in times of need.

It is evident that Brentwood has, in many ways, followed the model outlined by A.A. Group leaders interviewed at Brentwood state that the core of the program is about looking at yourself, and that the level of introspection that is necessary to get at the core of the disease can only occur through sharing and talking about feelings (Interview 1 & 2, 2000, Interview 5, 2001). This introspection is derived from Step 4 in A.A., which states, "make a searching and fearless moral inventory of yourself" (Jensen, 2000, p. 54).

Upon admittance, members at Brentwood are placed in "home groups" that they meet with daily from their first day to graduation. Most of the members’ time is spent with their home group, whom they quickly come to trust and are willing to open up to and share their experiences with. In the home groups, recovering alcoholics are taught to share and confide in one another, and to offer each other support and hope (Interview 3, 2001). One member on program at Brentwood during summer 2001 stated that her home group, and the women in particular, was like a second family to her, and that this connection was established in the early stages of her recovery at Brentwood (Conversation 8, 2001).

The familial atmosphere that is promoted is a fundamental component of the narrative nature of the program. The comfort level that is cultivated from the outset is apparent when observing the depth and breadth of the emotions and feelings that are freely expressed during group discussions (Observations, 2001). The events that are discussed during the course of these group sessions include events in members’ pasts that they may regret, or feel ashamed of, in the hopes of purging the feelings that are tied to
the event. The core of the program is based on dealing with these emotions as they surface, to help the member understand why they drink (Interview 5, 2001).

The web site information reviewed for this project suggests that the process of recovery in Native treatment centres involves the use of narratives. In many Native treatment programs, the sharing of narratives takes place within a healing circle. During this group process, specific emotional wounds are discussed for the purpose of letting go of those emotions and focusing one’s energy on recovery (Coyhis, 2000, pg. 110). Healing circles are a way for people to gather for support and to share their stories about the effect of alcoholism in their family and community (www.naigso.org). It is a group process that supports the sobriety journey for some Native people. In a healing circle, people speak one at a time and listen to one another; they allow each person to be heard, giving them a stake in the outcome of the proceedings (Coyhis, 2000, p. 110). Coyhis states that, in a healing circle, specific emotional wounds are brought up, shared within the ceremony of the healing circle, and let go under the directions of a person who knows how to conduct a healing circle (p. 110).

Group discussions in A.A., Brentwood and Native programs are used to promote the free expression of feelings and emotions that members are experiencing in the hopes that other members will be able to help deal with the issues raised. It should be noted, that while membership of the therapeutic groups in the A.A. model is open and voluntary, there might be a degree of selectivity involved. To put this very specifically, similarities in the social-economic and cultural background of participants may well be at work in group formation. I must stress that the research for this research was not designed to pursue this issue. Hence no conclusive statements about this issue can be made. Still, it
can be suggested that there is nothing inherent about the approach that precludes the
formation of groups with members from similar backgrounds and the incorporation of
difference into group processes. The preceding comparison suggests that similar
approaches to treatment used in Native and non-Native facilities provide a context in
which Native recovery programs are given some cultural freedom to customize the
approach to support their cultural differences however they are defined.

**Conclusion**

This discussion has reviewed Alcoholics Anonymous, Brentwood Recovery
Home and Native recovery programs to outline the similarities that exist within each
mode of treatment. More specifically, comparisons were made based on structural
components, including the sharing of stories and incorporation of A.A. values and beliefs
into treatment methodologies, as well as philosophical tenets that included the nature of
fellowship together with spirituality and the emphasis on holistic treatment.

The parallels outlined above support the notion that Native recovery programs
function as a reflection of most treatment technologies couched in the discourse of
cultural specificity. This analysis has reviewed how A.A. principles are arranged to
permit the development of culturally distinct treatment approaches.
CHAPTER XI

Conclusion

Native communities experience rates of alcoholism and abuse that are largely above those found in other communities. Several theories have been developed, and were outlined previously, in an effort to rationalize Aboriginal substance abuse patterns. This research project does not attempt to investigate the reasons behind the high rates of alcohol use and abuse among Indigenous groups. Instead, the questions that were explored pertain to the development of drug and alcohol abuse treatment facilities for Native peoples. Specifically, I asked how the apparent contradiction between treatment programs based on A.A. principles and the need for therapies grounded in the notion of cultural difference is managed? A related question was asked that addressed the development of NNADAP sponsored programs and how they affected the move of Indigenous groups toward self-determination?

The adoption of similar treatment technologies by Native and non-Native recovery programs is evaluated on a general level through selected interview data, literature and web site information. I have outlined the background, development, organization, and founding principles of Alcoholics Anonymous, Brentwood Recovery Home, and Native recovery programs in an effort to draw a comparison on a structural and philosophical level. More specifically, these programs were analysed based on the sharing of stories or narratives, incorporation of A.A.'s general values and beliefs, the nature of fellowship together with spirituality and the emphasis on holistic treatment.

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This research found that one of the greatest similarities in addictions treatment, regardless of the target population, is its use of particular narratives. In A.A., Brentwood and Native treatment programs recovery revolves around the sharing of stories with other alcoholics and group leaders in an effort to look inside oneself for the truth that led them to drink. It is believed that this search for truth can only occur with the help of other alcoholics. Although the act of sharing stories in treatment is labeled differently from one treatment program to another, the practice of forming small groups for the purpose of discussion remains the same. This parallel suggests that the fundamental treatment method used in A.A., Brentwood and Native programs is similar despite the different philosophies held regarding the importance of distinctiveness.

The use of A.A.'s fundamental values and beliefs, including the integration of the twelve steps, was a structural tenet that was examined for the purpose of this comparison. In addition, philosophical connections were made based on the importance of fellowship and spirituality, and the focus on holistic treatment. When A.A., Brentwood and Native recovery programs were compared and analysed, each program seemed to support, and rely on, the notion of fellowship and insisted that it was a necessary element of any recovery program. Similarly, the emphasis on spirituality, defined as addressing strengths and weakness in an effort to attain a balanced life, and the focus on holistic treatment were recognized as principle components in A.A., Brentwood and Native treatment programs. These similarities serve as the foundation for my suggestion that Native recovery programs are a reflection of existing treatment technologies.
Historically, segregation and observation were strategies used by the Federal
government to govern Native Canadians. The Federal government has moved from
policies of assimilation to recognition of difference. I suggest that the implementation of
Canada’s multiculturalism policy launched the shift from government regulation of
Native peoples to self-management. The renewed relationship between the Federal
government and Native communities, based on the desire to transfer the control of health
services to First Nations and Inuit people, has afforded Indigenous groups the opportunity
to exercise authority to solve the problem of alcoholism in their own communities.

As discussed in the literature review, the identity associated with Native peoples
is often termed Aboriginality, which is part of a discourse surrounding the distinctiveness
of Aboriginal people. Once a particular “Aboriginal Identity” is formulated, the very
formulation acts to produce a reality within which individuals may find identity and
which calls forth certain behaviour. The construction of a collective “Aboriginal
Identity” homogenizes Native peoples into restrictive categories of “other.” However,
Native treatment programs can be managed at the local level to permit “culturally
specific” modes of treatment that may help foster the formation of distinct identities.

This paper has argued that applying the A.A. model, despite its emphasis on
sameness, allows room for the incorporation of difference into the treatment process.
Native facilities recognition of distinctiveness permits treatment to be applied in a less
inclusive way.

Generally, Indigenous groups have required assistance to address the problem of
alcoholism in their communities. Although Native programs rest on a treatment approach
that does not account for difference, there seems to be a degree of what might be called ‘cultural freedom’ that allows program coordinators to invoke “tradition” as they see it.

Comparisons have been made between A.A., Brentwood and Native treatment facilities based on structural and philosophical components. I suggest that although the three recovery approaches seem to use similar methods, the way in which the methods are carried out may be an area where Native treatment facilities can incorporate difference into the treatment program, giving Aboriginal communities a voice in the recovery process.

**Possibilities for Further Research**

In light of the conclusions drawn from this project, it is clear that further examination of Native and non-Native alcohol treatment programming is required. The following questions were generated during the course of this research and may be possible themes for future analysis. What constitutes “traditional treatment methods” in Native recovery programs across Canada? How do these methods differ from one region/band to another? What are the “success rates” of Native participants in Native recovery programs in comparison to non-Native programs? How is identity constructed in Native communities?

Investigating Aboriginal issues, as a non-Native Canadian, was a difficult undertaking as a result of the manner in which information is shared within Native communities. Recognizing and respecting the process of storytelling, use of oral histories, discussion and ceremonies limits the degree and depth that one can gather knowledge about social problems as experienced by Canada’s Native population. The
disparity of existing information and individual opinion, coupled with a rich history, and unique social fabric, make the perspectives of Canada's "original people" a subject that warrants further investigation, despite any barriers that may be faced along the way.
Appendix A

Typical Day at Brentwood

Father Charbonneau sets the topic for the day (although the topic usually remains the same for the whole week).
Topics include: (these topics are outlined in Dr. Gallant’s book “Alcoholism and Brentwood – A Spiritual Model of Recovery”)

- Acceptance
- Appreciation
- Balance
- Caring
- Change
- Confiding
- Communicating
- Fear
- Freedom
- Pre-judging people
- Reliability

8:00am-9:10am - one on one session
9:10am-9:30am – coffee break
9:30am-10:00am – group session
(During group they make commitments, decide on an action that they can do for the good of themselves)
10:00am break
10:30am-11:00am Father Charbonneau talks on the theme/topic of the day – alumni and staff share
11:00am-12:00pm residents break into groups to share and discuss what they got out of Father’s talk
12:00pm-1:00pm lunch
1:00pm-1:50pm inventory meeting (sharing how they’ve hurt someone)
1:50pm-2:10pm coffee break
2:10pm-3:00/3:30pm group meeting on the theme/topic of the day
Free time
5:00pm mealtime
After the meal it’s fellowship until 6:30pm
6:30pm-7:00pm one on one (what the theme/topic triggered – about yourself)
7:00pm-8:00pm group meeting – leader talks for 10-15 minutes on the theme/topic, then members break into groups
8:00pm break
8:30pm inventory meeting
Appendix B

Brentwood Interview Questions:

What is the aim of the programming at Brentwood?
What are the main components of the program?
Are the programs offered considered to be appropriate for people of various backgrounds and beliefs?
What are some of the fundamental philosophies to AA based treatment?
How is difference, in terms of background and belief, understood in AA?
Are you aware of the drug and alcohol treatment centres that are designed for and run by Native people?
Do you see the need for distinct facilities for this particular group of people, or do you believe that their needs could be met in a facility like Brentwood? Why?
What role, if any, do you feel spirituality plays in the programming that is offered at Brentwood and why?
Tradition seems to be an important aspect of the treatment that is offered in Native rehabilitation centres, do you think that its use may be similar to how spirituality is used here?
Are there any specific programs that Brentwood offers that you feel would be of particular use to Aboriginal alcoholics? What are they and why do you think they would be useful?
Why is Brentwood successful?

Brentwood Interview Questions (modified 1):

What is the aim of the programming at Brentwood?
What are the main components of the program?
Are the programs offered considered to be appropriate for people of various backgrounds and beliefs?
What are some of the fundamental philosophies to AA based treatment?
What are the similarities and differences between Brentwood and AA?
Are you aware of the drug and alcohol treatment centres that are designed for and run by Native people?
Do you see the need for distinct facilities for this particular group of people, or do you believe that their needs could be met in a facility like Brentwood? Why?
What role, if any, do you feel spirituality plays in the programming that is offered at Brentwood and why?
Are there any specific programs that Brentwood offers that you feel would be of particular use to Aboriginal alcoholics? What are they and why do you think they would be useful?
Why is Brentwood successful?
Brentwood Interview Questions (modified 2):

What is the aim of the programming at Brentwood?
What role, if any, do you feel spirituality plays in the programming that is offered at Brentwood and why?
What are the similarities and differences between Brentwood and AA?
It has been stated that people are treated the same at Brentwood regardless of their background and beliefs. Do you think that any of the treatment offered here suppress a persons individuality or identity?
Are you involved in the group and one-on-one treatment sessions? What approaches are used in these sessions to help aid in recovery?
Are you aware of the drug and alcohol treatment centres that are designed for and run by Native people?
Do you see the need for distinct facilities for this particular group of people, or do you believe that their needs could be met in a facility like Brentwood? Why?
Dr. Gallant’s book states that one of the prerequisites that is necessary for a person to enter Brentwood, and be successful is to have a sense of a shared community through the experience of strong relationships. Do you think it is possible for a Native person to achieve this?
Dr. Gallant’s book also states that alcoholism is a spiritual affliction. Is that a term that is used at Brentwood, if so, what does it mean?
What is the role of the Brentwood Alumni?
Are the Alumni tracked after they leave Brentwood?
Are you aware of any active Alumni that are of Native descent?
Why is Brentwood successful?
In your opinion, is there anything that could be added to, or changed in the program to make the program more successful?
Appendix C

**Can Am Friendship Centre Interview Questions:**

What is the aim of the programming at the Can Am Centre?
What are the main components of the program?
Are there any restrictions on who can use the programs that the Can Am Centre offers?
When offering programming, how do you account for the diversity of Indigenous populations?
Do you think that some Native people would benefit more from a program that is not designed solely for Aboriginal people?
Do you feel that there are any specific benefits or limitations to being treated in a program that is designed for Native peoples? If so, what are they?
Do you feel that “tradition” plays a role in the treatment of Alcoholism?
What does “tradition” mean to you?
Do AA philosophies play a role in the programming at the Can Am Centre? If so, how?
Do you think these philosophies are used in the same way at the Can Am Centre as at other facilities that are not specifically designed for Native peoples?
What do you think about the concept of a distinct Aboriginal identity?
Do you think this relates to alcoholism, how?
Appendix D

Fr. Charbonneau’s Interview Questions:

How would you define the problem of addiction?
What role does spirituality play in the programming that is offered at Brentwood?
Has Brentwood modified or developed approaches that are used in AA to fit the programming here?
What approaches are used in group, and one-on-one sessions to help aid in recovery?
Are these methods appropriate for everyone?
Do you see the need for distinct treatment facilities for Native people, or do you believe that their needs could be met in a facility like Brentwood? Why?
Do you believe that the problems that Native peoples face are different than the problems of other alcoholics?
Are you aware of any barriers to Native people opening up their hearts through the treatment they receive at Brentwood?
Are there factors that might undermine the effectiveness of the program for Native peoples?
What sort of people manage better in this type of program, are there people who don’t do as well?
Have you noticed a change over-time in clientele? If so, do these changes necessitate change in programming?
What direction do you see Brentwood going in the future?
Details of staff (How many? Titles? Responsibilities? Background?)
Are residents still given a home group that they stay with from day one until the end?
Native A.A. Leader's Format

1. Welcome to the ____________ meeting of Alcoholics Anonymous. My name is ____________. I'll be your alcoholic leader for the evening.

2. "For those who wish, could we have a moment of silence for those who still suffer, followed by the Serenity Prayer.... God - Grant me the serenity to accept the things I can not change, the courage to change the things I can, and the wisdom to know the difference."

3. "Alcoholics Anonymous is a fellowship of men and women who share their experience, strength, and hope with each other that they may solve their common problem and help others to recover from alcoholism. The only requirement for membership is a desire to stop drinking. There are no dues or fees for A.A. membership; we are self-supporting through our own contributions. A.A. is not allied with any sect, denomination, politics, organization or institution; does not wish to engage in any controversy; neither endorses nor opposes any causes. Our primary purpose is to stay sober and help other alcoholics to achieve sobriety."

4. I'm going to turn the meeting over to the secretary for announcements, reports, tokens, and anniversaries.

5. "Tonight I have asked ____________ to read a portion of Chapter Five - "How it Works."

6. "Tonight I have asked ____________ to read a portion of Chapter Three - "More About Alcoholism."

7. * The last meeting of the month: "Tonight I have asked ____________ to read the "Twelve Traditions of Alcoholic Anonymous."

8. * The last meeting of the month: "Tonight the Native American traditions pertaining to the use of an eagle feather in a talking circle will be read by the Caretaker of the feather."

9. In May of 1935, Bill W., a New Yorker, away from home on a business trip to Akron, Ohio, sought out another alcoholic, Dr. Bob S., so that in sharing their experience, strength, and hope with each other he might remain sober if only for that day. It worked: He stayed sober and Bill
W. and Dr. Bob became the first two members of what was to become Alcoholics Anonymous and sharing became the basis for A.A. meetings. Tonight we are gathered together to share our experience, strength, and hope with each other so that we might remain sober if only for today. The suggested format for sharing is to relate in a general way what it used to be like, what happened, and what it is like now.

10. "Not to embarrass you, but to get to know you better at the end of the meeting, if you have less than thirty days of sobriety, please introduce yourself by your first name.... Welcome!"

11. "Are there any visitors or first timers with us tonight? .... Welcome!"

12. "At this time, we'll go around the circle and introduce ourselves.... My name is ________________ and I am an alcoholic."

13. "This is an open meeting of Alcoholic Anonymous. We are glad that you are all here - especially the newcomers. The meeting will last until the circle has shared. If you have to leave early, feel free to do so. Please limit your sharing to five minutes to allow the complete circle to share in a timely manner. Tonight I've chosen the topic ________________

14. At a convenient time after all have arrived and before anyone leaves, pass the basket.

15. After all have shared, announce: "There are no dues or fees for A.A. membership. In accordance with the 7th tradition which states that every A.A. group ought to be fully self-supporting, declining outside contribution, the basket has been passed for expenses and support of the overall services of A.A."

16. I have asked ________________ to read a portion of the "Big Book" entitled "The Promises".

17. I have asked ________________ to read the "Indian Prayer."

18. Turn the meeting over to the secretary for the closing remarks and prayer.
Leaders Closing

1. Make appropriate acknowledgments. For example, the evening's leader, tokens received, newcomers, etc.
2. All stand in a circle holding hands. Choose someone to lead in the prayer of their choice. The leader for the evening meeting breaks the circle in a clockwise direction, greeting each one in turn with handshake or hug. Others, in like manner, follow.

(Source: www.naigso.org)
Native A.A. Secretary's Format

1. Announcements, reports, tokens, and anniversaries?

2. Are there any tokens or anniversaries for next week?

3. The bathroom is ____________ . The light switch is located ____________.

4. If desired, obtain a volunteer to lead next week's meeting.
5. The ____________ meeting of A.A. supports incorporating traditional Native American customs into the order of the meeting. These customs include; the burning of sage, singing (with or without a drum), and using an eagle feather. To honor the Sacredness of Native American Traditions and oneself, please refrain from the use of profanity, swearing, etc.

6. When the eagle feather is passed around, a person may choose to hold it or let the person next to them hold it while sharing. This is completely O.K.

7. The burning of sage is call "smudging". It is traditionally used to prepare and purify a person, place, or thing for a time of openness and truth in the presence of our Creator. Prior to the meeting the room is smudged. The eagle feather is smudged before use. The sage is passed around the circle for each person to smudge. If you prefer not, pass it on to the next person in the circle. The sage and a book of matches will be made available for late arrivers to smudge. Please reposition your chairs and enlarge the circle to include them, as they come in.

8. Traditionally, the leader will share, then sharing proceeds around the circle in a clockwise manner. It is believed through the circle of life we are connected to all things. It is believed through this manner of sharing, we hear our inner wisdom better.

9. To empower the healing strength of the circle it is suggested that there be no "cross-talk" while the circle is sharing.

10. Return the meeting to the leader.

11. At 9:00 P.M., if it is apparent that the meeting will run late announce, "It's about 9:00 o'clock. The meeting will continue until the complete
circle has shared. If you have to leave, we understand - thanks for coming and keep coming back."

(Source: www.naigso.org)
References


National Film Board of Canada. (1994). *Poundmaker’s Lodge: A healing place*. Montreal, PQ.


Vita Auctoris

Kelly Little (Henley) was born in 1976 in Kingston, Ontario. In 1995, she graduated from Henry Street High School in Whitby, Ontario. From there she went on to the University of Windsor where she obtained an Honours B.A in Sociology and Criminology in 1999. She is currently a candidate for a Master’s degree in Sociology at the University of Windsor and will graduate in June 2002.